STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE

REQUEST FOR PROPOSALS # 31865-00600
AMENDMENT # 7
FOR Pharmacy Benefits Manager

DATE: 11/16/2018

RFP # 31865-00600 IS AMENDED AS FOLLOWS:

1. **This RFP Schedule of Events updates and confirms scheduled RFP dates.** Any event, time, or date containing revised or new text is highlighted.

EVENT	TIME (central time zone)	DATE
1. RFP Issued		September 4, 2018
2. Disability Accommodation Request Deadline	.	September 7, 2018
3. Pre-response Conference	2:00 p.m.	September 13, 2018
4. Notice of Intent to Respond Deadline	2:00 p.m.	September 17, 2018
5. Written "Questions & Comments" Deadline	1:00 p.m.	September 24, 2018
6. State Response to Written "Questions & Comments"		November 16, 2018
7. Response Deadline	12:00 p.m.	December 3, 2018
8. State Completion of Technical Response Evaluations		December 17, 2018
9. State Opening & Scoring of Cost Proposals	2:00 p.m.	December 19, 2018
10.State Notice of Intent to Award Released and RFP Files Opened for Public Inspection	2:00 p.m.	December 21, 2018
11.End of Open File Period		January 2, 2018
12.State sends contract to Contractor for signature		January 7, 2019
13.Contractor Signature Deadline		January 11, 2019
14. Contract Start Date (Implementation Begins)		March 7, 2019

2. **State responses to questions and comments in the table below amend and clarify this RFP.**

Any restatement of RFP text in the Question/Comment column shall NOT be construed as a change in the actual wording of the RFP document.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
B.15	Pg. 23	1 Is there a specific diversity goal for this procurement? How will supplier diversity impact evaluations and scoring?	No. Please see 5.2.1.3
C.14	Pg. 31	2 Does any current training exist? If so, please detail the following information, by topic, for training: a. Types of courses b. Number of each type of course c. Duration / length of each type of course d. If eLearning, what is the development tool used e. Is eLearning required to be 508 compliant f. Number and length of FAQs, QRGs, etc. g. For each eLearning module please classify level of interactivity based on the following: i. Level 1 -Static CBTs feature static pages with linear navigation that result in passive interactivity ii. Level 2 - eLearning CBTs feature interactive content, drag-and-drop activities, built-in quizzes, animation, and audio that result in limited participation interactivity. iii. Level 3 - Motion CBTs feature dynamic motion graphics, music, and live action videos that result in complex participation	No. The State is looking to the respondents for their training capabilities and methodologies.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		interactivity. h. Designated job role for each training course i. Current training delivery schedule	
A.6.a. 1	Pg. 53	3 Same Question as #2 above.	See the answer to question #2.
A.7.a 4	Pg. 61	4 Same Question as #2 above.	See the answer to question #2.
A.22	Pg. 74	5 Same Question as #2 above.	See the answer to question #2.
A.22.c	Pg. 74	6 Same Question as #2 above.	See the answer to question #2.
A.25.a	Pg. 77	7 Same Question as #2 above.	See the answer to question #2.
A.41.g 3,4,5	Pg. 99	8 Same Question as #2 above.	See the answer to question #2.
16	Pg. 147	9 Same Question as #2 above.	See the answer to question #2.
6b	Pg. 213	10 Same Question as #2 above.	See the answer to question #2.
A.41.g	Pg. 99	11 Does the State have a preference for delivery of the training sessions (i.e. instructor led vs. webinars vs. videos vs. e-learning modules)? How many sessions are anticipated? How many estimated stakeholders will attend each training session?	The State does not have a preference. Please see the answer to question #2.
A.41.b	Pg. 93	12 Does the State have a PMO established to support the implementation? If not, will the State assign a dedicated project manager to manage DDI and CMS Certification tasks owned by the State?	Yes, the State has a PMO established to support the implementation. The state will provide the necessary PMO documentation that outlines the roles and responsibilities of the different parties as part of the onboarding process of the selected contractor.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		If so, will the state provide a copy of the scope of work for the project manager?	
A.41.b	Pg. 93	13 Has the State completed its consultation with CMS to define the checklists that will be used to certify the system? If so, can the State provide copies of the agreed upon checklists? If not, does the State have a timeline for completion of this activity?	Yes, the state has completed its consultation with CMS to define the checklists that will be used to certify the system. The agreed upon checklists are referenced in Section A.41.b of the RFP, and part 9 of the Attachment 6.7 (Bidder's Library)
A.41.b	Pg. 93	14 Has the state completed a Project Partnership Understanding (PPU) with CMS for this project? a. If so, will the state provide a copy of the PPU?	Yes, the state completed a Project Partnership Understanding (PPU) with CMS for this project. The state will provide the necessary components of the PPU as part of the onboarding process of the selected contractor.
A.41.b	Pg. 93	15 Does the State have a systems integrator in place or plan to procure a systems integrator to provide infrastructure solutions in support of the solution? If so, can the State provide the name of the SI and the type of platform that the SI has implemented (or will implement)? If not, how does the State plan to manage the integration of individual modules into a cohesive Medicaid enterprise?	Tennessee does not plan to procure a single systems integrator. Tennessee is already very modular with over 20 modules with various vendors. TennCare has deployed a modular systems integration framework, with TennCare maintaining architectural control, using a structured governance framework to ensure the integration of various modules into a cohesive Medicaid enterprise solution. TennCare leverages a data center that is managed by a sister State Agency, with appropriate disaster recovery and business continuity operations.
A.41.b	Pg. 93	16 Is the PBMS procurement a standalone project or part of a broader Medicaid Enterprise Solution replacement? If this project is part of a	This procurement is a standalone project.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		larger modernization, can the state provide the roadmap for the modernization?	
A.41.b	Pg. 93	17 Has the State received CMS approval of an Implementation Advanced Planning Document (IAPD) for this project? If so, can the State provide a copy of the approved IAPD?	Yes, the State received CMS approval of an Implementation Advanced Planning Document (IAPD) for this project. No, the state will not provide a copy of the approved IAPD
A.41.b	Pg. 93	18 Has the state contracted with an Independent Verification and Validation (IV&V) vendor to provide oversight of this project? If so, can the state provide a copy of the scope of work for the IV&V contractor?	TennCare has a contractual agreement in place for independent verification and validation services. It aligns with the scope that has been mandated for IV&V services by CMS for all state Medicaid Enterprise Systems. The language provided by CMS has been incorporated into the current contract and is in alignment with the Medicaid Enterprise Certification Toolkit version 2.3.
A.41.b	Pg. 93	19 Page 93, A.41.b states, "The Contractor shall provide, no later than December 1, 2019, all finalized TennCare PBM System artifacts and documentation that CMS requires." a. Question: It is not possible to provide evidence from the production environment required for final certification (R3) review of the solution before go-live (CMS requires that R3 evidence be sourced from production, including actual claims and client data). Would the State consider amending the required date to provide all artifacts and documentation until sometime after go-live to allow the solution vendor to	The State understands that production evidence will not be provided to CMS until 6 months after Go-Live. However, system documentation and artifacts must be available prior to Go-Live for the R2 Review.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		gather required certification evidence from the production environment?	
Agreement attachment I, Section 1.1 / RFP A.41.b	Pg. 298 / 94	20 The "SAMPLE ADMINISTRATIVE AND ESCROW AGREEMENT REGARDING WITHHOLD AND ESCROW OF PART OF CONTRACTOR'S TennCare ADMINISTRATIVE FEES PENDING CMS CERTIFICATION OF CONTRACTOR'S TennCare PBM SYSTEM" states that the initial certification request will be submitted on January 3, 2020 (Section 1.1, page 298), whereas section A.41.b, number 2, page 94) states that the initial certification request will be submitted July 1, 2020. a. Question: Can the state clarify the target date for submission of the initial certification request?	Per section 3.4.1 of the 01 MECT 2_3 Medicaid Enterprise Certification Life Cycle, "the system or module must have been in operation for at least six months before certification can be granted. At least six weeks prior to a desired final milestone review date and often even earlier, the state discusses with CMS its desire to have a certification milestone review."
A.41.b	Pg. 93	21 MECT 2.2 requires a pre-go-live R2 review. Does the state intend to complete an R2 review for the PBMS? a. If so, will the State require CMS deliver its feedback on the R2 prior to solution go-live?	The State will consider CMS' input and guidance for the decision to go live with the solution.
A.41.c, number 7	Pg. 97	22 Section States, "7. Medicaid Information Technology Architecture (MITA) Maturity Assessment. The Contractor shall work with TennCare project staff to assess the MITA maturity gains expected from the implementation of the system, and the Contractor	Yes

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		shall work with the State in their effort to complete, and submit to CMS, their MITA State Self- Assessment Scorecard." a. Can we assume that the support that the state requests related to completion of the state's SS-A scorecard is specific to those elements impacted by the PBM implementation (not completion of the full SS-A scorecard for the full Medicaid program)?	
A.43.e	Pg. 121	23 In alignment with CMS policy whereas manufacturers have 37 calendar days to submit payment and interest accrual begins on day 38, will the State consider revising the late notification schedule 45, 75 and 90 day to 38, 68, 108 and 138 days?	Recognizing that each respondent uses different systems for rebate management, The State will renegotiate this schedule during implementation meetings.
Section 4.8 Disclosure of Response Contents	Pg. 13	24 The RFP does not appear to reference any requirements about redacting portions of a proposal response or how to treat confidential/proprietary information. Does the State have any specific requirements around these issues?	RFP § 4.8 states: 4.8. Disclosure of Response Contents 4.8.1. All materials submitted to the State in response to this RFP shall become the property of the State of Tennessee. Selection or rejection of a response does not affect this right. By submitting a response, a Respondent acknowledges and accepts that the full response contents and associated documents will become open to public inspection in accordance with the laws of the State of Tennessee. 4.8.2. The State will hold all response information, including both technical and cost information, in confidence

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
			during the evaluation process. 4.8.3. Upon completion of response evaluations, indicated by public release of a Notice of Intent to Award, the responses and associated materials will be open for review by the public in accordance with Tenn. Code Ann., § 10-7-504(a)(7).
Attachment 6.2, C.12.	Pg. 30	25 Will the existing contractor turn over any portions of the current TennCare website or will the winning respondent be required to establish a new website?	No. Historical documents linked to the current website will be provided; however the winning respondent will be required to establish and maintain a new website. There is no protected data housed on the TennCare Pharmacy Website. Should protected data need to be transferred, it will remain so and within the appropriate chain of custody.
Attachment 6.6	Pg. 48	26 Is it the State's intention for the contractor to respond directly to any of the items included in Attachment 6.6, Pro Forma Contract?	Attachment 6.6, Pro Forma Contract, directly relates to the items listed within the Technical and Cost sections of the RFP. This section includes the Scope of the required services and should direct your response throughout the RFP. Questions that are not asked during the Q & C period may not be entertained upon award at the State's sole discretion. See RFP section 1.6. and 5.3.
Pro Forma Contract A.25.e	Pg. 78	27 Is it acceptable for the contractor to be approved as a Prepaid Ambulatory Health Plan (PAHP) upon contract award?	Yes. We are comfortable stating PAHP confirmed by contract award.
RFP - General		28 How many State users will require access to the end user applications for pharmacy claims adjudication, prior authorization, and rebate administration respectively? Does the State have a preferred solution for end-user connectivity to these	Adjudication System: HCFA's pharmacy department will require 9 users. Other department within HCFA (TennCare Solutions Unit, KePRO, Program Integrity, Internal Audit, etc.) and other State divisions will also require access (State Comptroller Auditors, Office of Inspector General, MFCU, etc.), along with users working with TennCare's MCO's.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		environments/ applications?	Prior Authorization System: HCFA's pharmacy department will require 9 users. Other department within HCFA (TennCare Solutions Unit, KePRO, Program Integrity, Internal Audit, etc.) and other State divisions may also require access (State Comptroller Auditors, Office of Inspector General, MFCU, etc.), along with users working with TennCare's MCO's. Rebate Administration: HCFA's pharmacy department has one primary person who will use this application, along with possible access needed for HCFA Finance and possibly one other HCFA pharmacy associate.
RFP - General		29 Will the State require access to test environments/applications? Does the State have a preferred solution for end-user connectivity to these environments/ applications?	The State will require access to the test environments/applications. Preference with regard to end-user connectivity to these environments/applications will be discussed during the onboarding process of the selected contractor.
Attachment 6.6, A.43.e	Pg. 120	30 Please provide the quarterly invoice volume for rebates.	Breakdown for 2Q2018: FFS- 500 invoices MCO- 145 invoices Supplemental- 46 invoices Diabetic supply- 2 invoices Total = 690 Invoices
Attachment 6.6, A.42.g	Pg. 114	31 Please provide the volume of claims processed annually for FFS and MCO.	TennCare's pharmacy program is carved-out from the MCO's, so there are no MCO pharmacy claims. See the answer to question #41.
Attachment 6.6, Section A.50.b.4	Pg. 155	32 RFP Language: "Contractor shall not impose limits on the number of licenses made available to State staff, designees, State and federal auditors, MCOs and other State entities" Can the State identify approximately how many	Please refer to the answer to Question #28.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		licenses are currently provided in order to meet this requirement?	
Attachment 6.6, A.55.c	Pg. 167	33 The requirement indicates that all contractors' key staff must attend the project kick-off meeting. However, per the key staff requirements, the Account Director is the only key position that must be hired beginning on the contract effective date. Per the RFP instructions on page 63 a.7.b.2, "All permanent Key Staff positions shall be hired and trained no less than sixty (60) days prior to TennCare CoverKids and CoverRx Go-Live." Can the State please clarify its expectations of which staff must be hired beginning on the contract effective date and which staff must be present for the project kick off?	The Account Director is the only Key Position that must be hired beginning on March 1, 2019. The State acknowledges that it is reasonable to expect that the Key Personnel available at Kick-Off could be Implementation team members. As stated in the contract, it is required that the permanent, Tennessee team must be hired and on site at least 60 days prior to go-live.
Attachment 6.6, A.8.a	Pg. 66	34 Can the State please provide an estimated volume of the following member materials that will need to be printed and mailed: member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, and system-generated letters?	The PBM is only responsible for the mailing of Pharmacy Identification Cards and Enrollee Notices. Approximately 4,500-5,000 ID cards are sent per month based on enrollee request. CoverRx-CY2016: ID Cards: 19,731 Welcome letters, notices, correspondences, checks: 73,390 Please refer to Item # 7 of this amendment for new RFP Attachment 6.7, Bidder's Library. Winning respondent will be responsible to mail initial ID cards and brochures to all pharmacy-benefit eligible enrollees for all three programs (excluding dual-eligible). Brochure could contain short lists of

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
			providers; however it is not necessary to mail out member handbooks and member directories to all enrollees. Traditionally some of this member communication has been handled by the MCO's. We have not required member newsletters in the recent past; however TennCare retains the right to make this request in the future, with pass-through cost to TennCare.
Attachment 6.2, C.13	Pg. 31	35 Could the State provide details on how it is currently using the services of MediSpan Drug Database (MDDB) and First Databank (FDB)?	The MDDB database is required for the provision of AWP and the 14-digit Generic Product ID (GPI) code. There is no requirement for use of the FDB database. The current PBM uses FDB as their primary database and uses all drug categories (GCN, GSN, HIC3, HICL) for drug lists and edits, DUR edits, etc.
Attachment 6.6, A.42.g.7	Pg. 115	36 What are the current professional dispensing fees?	Current PDF for the TennCare program are: Low Volume Ambulatory- $10.09 High Volume Ambulatory- $8.33 LTC- $12.15 Specialty- $10.09 340B claims from Covered Entities only- $15.40 Blood Factor - $153.54
Attachment 6.6, A.44.j	Pg. 129	37 How often are new enrollee cards printed and provided to enrollees? Is this a regular occurrence or only when they are newly eligible or report a lost card?	Enrollee ID cards are printed at the implementation of the new Contractor, and then on a weekly basis when enrollees are newly eligible, and when enrollees have reported lost cards.
Attachment 6.6, A.45.a	Pg. 133	38 How many DUR Board members are there and what is the reimbursement amount per meeting?	There are 11 DUR Board members. They are reimbursed for mileage and lodging if necessary directly from TennCare.
Attachment 6.6,	Pg. 137	39 Please provide historical or anticipated PA volumes for the TennCare program.	CY2017 PA volume = 281,406 1/1/2018-6/30/2018 PA volume =

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
A.46			167,465
Attachment 6.6, A.46	Pg. 137	40 How many enrollee-initiated PAs are there each month?	CY2017 enrollee-initiated PA volume = 15,235 1/1/2018-6/30/2018 enrollee initiated PA volume = 11,576
Attachment 6.2, C.5	Pg.28	41 Please provide paid claims volume for TennCare, CoverRx and CoverKids (approximate) separated out by plan.	TennCare paid claims FY 2018(July 2017-June 2018) 13,468,346 CoverRx: 235,000 1/1/2018-6/30/2018 CoverKIDS: 170,000: 1/1/2018-June 30, 2018
Attachment 6.6, C.14. A.43.e	Pg. 31 Pg. 121	42 Please define the type (electronic/paper), volume, and timeframes of historical data that would be transferred to the contractor.	Elect- claims, eligibility, providers, lists, MAC lists, lock-in, PA's, Paper- rebate related microfiches and contracts
Attachment C Attachment G	Pg. 271 Pg.291	43 In terms of the penalties assessed around the liquidated damages and performance metrics, can the State please confirm the contractor is not held responsible for not meeting deadlines when it is at the fault of another party?	Please refer to section E.10 and Attachment C in the *pro forma.*
A.45.a.1	Pg. 134	44 RFP language: "Recruit, maintain, and reimburse a panel of clinical pharmacists…" Will the State have any involvement in the recruitment process? In addition, what is the reimbursement amount and does it include mileage?	See A.45.a, for the description and functions of the DUR Pharmacist, provided by the winning respondent. The winning respondent will be responsible to generate the reports, letters and analyses described in A.45.a., along with planning, and presiding over the DUR Board quarterly meeting. This has been traditionally one FTE; however the winning respondent is responsible for all deliverables in A.45.a., regardless of the number of FTE necessary. This question does not involve the DUR Board, or reimbursement.
Attachment 6.6,	Pg. 136	45 The RFP states: "The data elements tracked will	TennCare has not provided hospitalization data to the PBM

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
A.45.b.1		vary according to the focus of study and/or type of intervention employed and may include, but shall not be limited to: (i) Hospitalizations and/or doctor visits pre and post intervention;" Based on our interpretation, in order to comply with this requirement, the contractor will require access to other claim types (aside from pharmacy). Will the State be able to provide these claim types?	vendors to this date. TennCare will provide the winning respondent with historical ICD-10 and Procedure codes. The State will not mandate DUR exercises that require additional health record data unless the State is able to provide the information to the winning respondent.
Attachment I (Escrow Agreement), 1.1 and 1.2	Pg. 299	46 Will the State consider delays in the certification timeline that are outside the control of the selected contractor when determining whether to institute the administrative fee withholdings? For example, delays in evidence review by the IV&V contractor, delays related to the CMS team's schedule, etc.	Based on the language in the contract, the Contractor will not receive the withheld amount until certification is complete, regardless of any delays by any parties. Permanent withhold is only applied if the Contractor fails to timely submit documents for certification.
Attachment 6.6, A.23.a	Pg. 75	47 Can the State please clarify what the expectation is regarding reporting of "tips" and what would be the expected solution as far as how tips are to be reported?	Investigations of potential or suspected fraud and abuse stem from allegations that a provider or supplier received Medicaid reimbursement for which he or she is not entitled under current Medicaid laws, regulations, or policies. Contractors are also required to submit tips of potential or suspected fraud and abuse by TennCare members to the Tennessee OIG. All allegations—or tips—must be reported to TennCare and screened by the Contractor in order to determine if additional investigation is warranted. Tips of potential or suspected fraud and abuse shall be submitted to TennCare OPI and TBI MFCU on the 1st and 15th of each month, and aggregated in the Quarterly Fraud and Abuse Report.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
			Requirements for the format and frequency of submitting tips of member fraud and abuse are set by OIG. Contractor shall report to TennCare OPI all tips submitted to OIG. All tip reports shall be submitted via the SFTP server.
Attachment 6.6, A.49.f	Pg. 154	48 Will the State require desk or on-site or both types of audits? How many of each type will the State require?	It is the State's expectation that all pharmacy providers will be subject to claims audits resulting in a request for further information as desk audits on a continual basis. See A.49.f., where it states "The Contractor shall conduct ten (10) field audits per quarter."
Attachment 6.6, A.43.b	Pg. 118	49 Reports from the Medicaid Evidence Based Decisions Project (MED) are required source materials. Is it the expectation that these reports would be available to the contractor via Tennessee's participation in that project or is the contractor expected to secure access to these reports?	The reports would be available to the contractor via Tennessee's participation with MED.
Attachment 6.6, A.43.d	Pg. 120	50 Is it acceptable to distribute meeting material exclusively by secure electronic means?	No. A hard copy of PAC meeting materials must be shipped or mailed and received by PAC members no less than twenty-one (21) business days prior to each PAC meeting.
Attachment 6.6, A.46.a.3	Pg. 138	51 The 42 CFR 438.210(b)3: Is it correct to assume that appropriately licensed pharmacists and physicians would meet the requirement of "appropriate expertise" to be able to render approvals and denials and that there is no expectation of specific provider type or specialist or sub-specialist physician	It is correct to assume as stated.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		input?	
Attachment 6.6, A.46.a.10	Pg. 139	52 Is the physician support expected to be available 24/7?	Yes.
Attachment 6.6, A.42.g.2	Pg. 114	53 Can the State please verify if the contractor will be responsible for setting the MAC prices for TennCare, CoverRx and/or CoverKids programs or is the contractor expected to use NADAC, AAC or any other actual acquisition cost drug file?	The winning respondent will be responsible for setting MAC prices for CoverRx and CoverKids, along with being responsible for maintaining AWP data from MediSpan. The winning respondent will be responsible to work with TennCare's pricing vendor, currently Myers & Stauffer, LLC, to receive and use TennCare's AAAC data. The winning respondent will also be responsible to maintain NADAC brand and generic pricing, WAC pricing and FUL pricing for the TennCare program.
Attachment 6.6, A.46.a.10.	Pg. 139	54 Is the physician availability for reconsideration and clinical support referred to in this requirement expected to be 24/7?	Yes.
Attachment 6.6, A.77.c	Pg. 221	55 Is it correct to assume that peer to peer suggests physician to physician contact in this instance and does not imply that the physician needs to be of any particular specialty or subspecialty?	Currently our PBM subcontracts with a provider of on-call physicians and physician specialists for peer-to-peer requests.
Attachment 6.6, A.46.d.6	Pg. 143	56 Since, based on the RFP text and the cited 42 CFR, TennCare will determine whether our proposed decision maker has "appropriate clinical expertise in treating the enrollee's condition or disease", can TennCare confirm if there will be an expectation of specific provider types or specialists or sub-specialists being provided for grievances and	Board certified physicians are acceptable.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		appeals, for example of like specialty to the requesting physician? Or will board certified physicians with broad training and experience particularly in drug utilization and review be acceptable?	
Attachment 6.6, A.77.c	Pg. 221	57 Please describe the current # of FTE of physicians working with the prior authorization unit and grievance /appeal procedures unit as well as the specialties of the involved physicians.	See the answer to Question #55. No physician FTE's are working with the call center.
Attachment 6.6, A.77.c	Pg. 221	58 How many reconsiderations that required physician input or peer to peer contact occurred over a recent 1-year period? How many grievances/appeals occurred over the last year?	There were 59 Peer to Peer reviews in 2017, and 57 reviews in 2018 through August. There have been 68 grievances since beginning this process in June of 2018.
Attachment D, Report #34	Pg. 284	59 Can the State please explain its expectation for calculating SRs on a monthly basis when the Federal Medicaid URA is not available until 1-4 months after a claim is processed?	This report is not about calculating SR's on a monthly basis. It is a tool for the PBM to report to HCFA on a monthly basis, any negotiations that have taken place, and the results, and any rates and possible savings that have been presented.
Attachment D, Report #23	Pg. 283	60 Other than market share/shift data, what data/information is to be included in the Clinical Initiative Report?	The State expects that the winning respondent will provide insight and consultative advice after examining results from clinical initiatives.
RFP - General		61 Is TennCare prohibited (by legislation or rule) from including any drug classes in the PDL program?	No.
RFP - General		62 Has CoverRx been designated by CMS as exempt from Best Price?	CoverRx is a State program. CMS has no authority over CoverRx.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
RFP - General		63 How many pharmacies are currently in the TennCare network? Can the State please provide a detailed listing of these pharmacies, including out-of-state pharmacies that may be enrolled within a 50-mile radius of TennCare state lines?	See RFP Attachment 6.7, Page 304 of the RFP.
Attachment 6.6, A.41.f	Pg. 98	64 What are the volumes on the first days of the month that should be used as a reference for testing load and stress?	FY2018, for the first 10 days of every month only, there were 11,216,939 total claims (paid, denied, etc.). The average daily for the first 10 days of each month was 93,475 claims. TennCare recommends a 15% increase for stress testing, approximately equaling 107,500 claims.
Attachment 6.6, A.41.e	Pg. 97	65 Is the Unit Test Plan referenced in this item related specifically to user acceptance testing (UAT) type of tests?	No, the Unit Test Plan refers to the developers test plan to test their own code before moving to an integration test environment where it is tested with other developers' code.
Attachment 6.6, A.42.a	Pg. 101	66 Regarding the requirement in the last paragraph to "process claims on batch electronic media": Would the State please clarify what is specifically meant in this requirement? e.g., CD/DVD of NCPDP D.0, SFTP of NCPDP Batch files, etc.?	Specifically, the claims will be delivered as questioned: CD/DVD of NCPDP D.0,, or SFTP of NCPDP batch files.
Attachment 6.6, A.42.d.16.	Pg. 110	67 Is the current contractor identifying products that should be a medical benefit, or is the State?	Currently both the State and the PBM discuss this.
Attachment 6.6, A.47.c.	Pg. 151	68 The RFP states: The Contractor shall install, operate, monitor and support an automated call distribution system that has capability to provide	Currently, only the State requires access to call recordings As the Medicaid agency, TennCare is permitted to obtain, access, and use PHI for members, as they grant permission and receive notice at the

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		messaging regarding time to live agent pick up, tele-FAQs and fax-on-demand. The contractor's system shall record all calls in a digital format. The contractor shall allow State staff to monitor calls in real-time and hear specific calls made to the Help Desk if the State provides the date, time or callers number. Please confirm that only State staff will need access to the call recordings. What are the State's actions on the enrollee's behalf in terms of gathering a PHI disclosure, which provides consent to release call recordings that contain PHI/PII? Is it permissible to provide recordings to the state in the form of WAV files through secure transmission as opposed to direct access into the vendor's internal tools?	time of application for benefits. As the contractor will act as a Business Associate of TennCare, PHI may be exchanged as appropriate and necessary under relevant regulations.
A.50.b A.59 A.78	Pg. 156 Pg.187 Pg.222	69 Can the State identify how many calls are expected to come into to the call center for each program (e.g., TennCare, CoverRx, and CoverKids)?	366,578 total calls for the TennCare program in 2017. For the first half of 2018, there were 175,073 calls. CoverRx- Approximately 2,000 per month. CoverKIDS--Calls pertain primarily to Mail Order questions and Prior Authorizations. Unable to provide specific numbers because currently CoverKIDS line of business is not separate from BCBST's overall calls.
Attachment 6.6, A.79.c.	Pg. 255	70 Does the State have up-to-date enrollee demographic data to utilize	Yes.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		for CoverKids survey mailings?	
Attachment 6.6, D.5	Pg. 238	71 Regarding Termination for Convenience: In the event there is such a termination, will contractor be compensated for any transition activities that may occur?	Please refer to Contract Sections C.3.2(1) and D.5.: C.3.2(1) For the transition period of March 1, 2019 – December 31, 2019, there shall be no cost to the State. D.5 Termination for Convenience. The State may terminate this Contract for convenience without cause and for any reason. The State shall give the Contractor at least thirty (30) days written notice before the termination date. **The Contractor shall be entitled to compensation for all conforming goods delivered and accepted by the State or for satisfactory, authorized services completed as of the termination date. In no event shall the State be liable to the Contractor for compensation for any goods neither requested nor accepted by the State or for any services neither requested by the State nor satisfactorily performed by the Contractor.** In no event shall the State's exercise of its right to terminate this Contract for convenience relieve the Contractor of any liability to the State for any damages or claims arising under this Contract.
Attachment 6.6, D.6	Pg. 238	72 Regarding Termination for Cause: Will the State consider increasing the termination for cause to 30 days, to be consistent with term for convenience?	See 5.2.3.2 of the RFP.
Attachment 6.6, D.7	Pg. 238	73 Regarding Assignment and Subcontracting: Will the contractor be able to assign to a successor-in-interest or as a result of a merger or change in control?	Please refer to Contract Section D.7.
Attachment	Pg. 241	74 Given the broad scope of	No.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
6.6, D.20.d		the indemnification, will the State consider replacing its broad indemnification with the following? "Indemnification. In the event of any unauthorized use or disclosure of Protected Health Information constituting a "Breach" as defined under 45 C.F.R. § 164.402 which is caused by the negligent act(s) or omission(s) of Business Associate, Business Associate agrees to indemnify STATE, to the extent Business Associate is responsible, from and against (i) any administrative fines or penalties assessed against STATE by the Secretary or other regulatory authority having jurisdiction; (ii) any award which may be made pursuant to a state Attorney General action and levied against STATE; and (iii) in the event of any such Breach requires the issuance of notice(s) to affected individuals pursuant to the relevant provisions of ARRA, all direct reasonable costs associated with production and delivery of such required notice(s). Business Associate's indemnification obligations under this section are subject to STATE (a) making written demand for indemnification from Business Associate pursuant to the foregoing; (b) to the extent STATE has notice of same, promptly notifying Business Associate of any investigation or the filing of	

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		any action by the Secretary, any State Attorney General, or other regulatory authority having jurisdiction; (c) granting to Business Associate the right to determine the means and methods by which any required notices are delivered to affected individuals (Business Associate hereby acknowledging that STATE shall retain the right to determine the content of same), and (d) granting to Business Associate the sole right to control any associated defense or negotiation for settlement or compromise. Business Associate agrees to work cooperatively with STATE to ensure that liability is properly determined and assigned by the Secretary or other regulatory authority having jurisdiction with regard to any such Breach."	
Attachment 6.6, A.51.e.	Pg. 160	75 Will eligibility for each of the 3 programs (TennCare, CoverRx, and CoverKids) be sent to the vendor separately?	Yes.
ProForma Contract A.5	Pg. 52	76 Are Control Memorandums negotiable after issuance, or subject to review by the vendor prior to final issuance by the State?	No. Control Memoranda can only be issued by the State and are not subject to review.
ProForma Contract A.8	Pg. 66	77 Does the State intend to grant a limited use license to the Contractor to allow the Contractor to include the State's name and marks in member materials?	See section E.7 Prohibited Advertising or Marketing. The Contractor shall not suggest or imply in advertising or marketing materials that Contractor's goods or services are endorsed by the State. The restrictions on Contractor advertising or marketing materials under this

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
			Section shall survive the termination of this Contract.
Pro Forma Contract A.10	Pg. 70	78 Will the state allow providers to negotiate any terms of the approved Provider Agreements?	See State's response to Question 72 above.
Pro Forma Contract A.10.b	Pg. 70	79 Will the State bear the cost of the investigation and audit of a provider that has been disciplined or sanctioned by the State Pharmacy Board or federal authorities?	No.
Pro Forma Contract A.18	Pg. 72	80 Will the State agree to limit audits to (I) no more than once during any 12 month period, or no more than once per fiscal year, and only during regular business hours and in a manner that is minimally disruptive to Contractor's regular business operations?	No.
Pro Forma Contract A.25.a	Pg. 77	81 Will it be acceptable to the State if Contractor's chief compliance officer reports to the General Counsel, who reports to the CEO?	Based on 42 C.F.R. § 438.608(a)(1), the compliance officer must report to the CEO and the board of directors. It will not suffice for the compliance officer to report to the general counsel.
Pro Forma Contract B.2	Pg. 231	82 Will any of the terms and conditions of the contract be open for renegotiation upon renewal of the term?	See section D.3 of the ProForma Contract.
Pro Forma Contract D.5	Pg. 238	83 Will the State consider providing 90 days advanced notice of its election to terminate the Contract for convenience?	See the response to question 72 above.
Pro Forma Contract D.18	Pg. 240	84 Will the State consider a reciprocal disclaimer of Contractor's liability for indirect, special, incidental,	No.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		punitive, exemplary, or consequential damages?	
Pro Forma Contract D.19	Pg. 240	85 Will the State consider limiting Contractor's indemnification obligations to third party claims?	No.
Pro Forma Contract D.20.d	Pg. 241	86 Will the State consider reimbursement of actual costs related to a breach of the Privacy Rules, instead of broad indemnification?	No.
Pro Forma Contract E.9	Pg. 248	87 Will the State consider allowing Contractor to control the defense of the claim; provided that Contractor will not settle any claim without approval of the State?	No. See D.19 of the Pro Forma contract and Tenn. Code Ann. § 8-6-106.
Pro Forma Contract E.11	Pg.249	88 Will the State consider deletion of this section from the Contract?	No.
Pro Forma Contract E.13	Pg. 249	89 Will the State permit inclusion of a knowledge qualifier to the provision "Contractor agrees it shall not do or omit to do anything which would cause the State to be in breach of any Privacy Laws."?	See the response to question 72 above.
Pro Forma Contract E.13	Pg.249	90 Will the State agree to limit Contractor's obligation to provide credit monitoring services to no more than one year?	See the response to question 72 above.
Pro Forma Contract E.21.g	Pg. 254	91 Will the State agree to allow Contractor to conduct an internal investigation of any loss or suspected loss of data prior to notifying the State?	See the response to question 72 above.
HIPAA Business Associate Agreement	Pg.3	92 Would the state consider adding the following data de-identification language? Business Associate may	See the response to question 72 above.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
2.3		de-identify PHI in accordance with 45 C.F.R. § 164.514(b) and may Use or Disclose such de-identified data unless prohibited by applicable law.	
HIPAA Business Associate Agreement 2.3	Pg. 3	93 Would the state consider referencing the data aggregation citation in HIPAA?	Data aggregation is defined under HIPAA at 45 CFR 164.501.
HIPAA Business Associate Agreement 2.5	Pg. 3	94 Can the state agree to "substantially the same restrictions"?	No.
HIPAA Business Associate Agreement 2.6	Pg.4	95 Would the state agree to the vendor cooperating with State's efforts to mitigate any harmful effects?	See the response to question 72 above.
HIPAA Business Associate Agreement 2.7	Pg.4	96 Would the state agree to 15 business days for all notifications?	See the response to question 72 above.
HIPAA Business Associate Agreement 2.8.3	Pg.4	97 Would the state agree to the proposed language as follows? Covered Entity shall make the final determination whether the Breach requires notification to affected individuals and notification shall be made by Covered Entity	See the response to question 72 above.
HIPAA Business Associate Agreement 2.9	Pg.4	98 Would the state agree to the proposed language? To the extent Business Associate agrees in the Services Agreement to maintain PHI in a	See the response to question 72 above.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		Designated Record Set that is not duplicative of a Designated Record Set maintained Covered Entity, Business Associate agrees to provide access to PHI in a Designated Record Set to Covered Entity in order to meet its requirements under 45 C.F.R. § 164.524. If Business Associate receives a request for PHI from an Individual Business Associate shall direct the Individual to Covered Entity.	
HIPAA Business Associate Agreement 2.10	Pg.4	99 Would the State agree to striking this language? This is typically a Covered Entity's obligation under HIPAA.	See the response to question 72 above.
HIPAA Business Associate Agreement 2.11	Pg.5	100 Can the State agree to the following language? To the extent Business Associate agrees in the Services Agreement to maintain PHI in a Designated Record Set that is not duplicative of a Designated Record Set maintained Covered Entity, Business Associate agrees to make such information available to Covered Entity for amendment within twenty (20) days of Business Associate's receipt of a written request from Covered Entity.	See the response to question 72 above.
HIPAA Business Associate Agreement 2.13	Pg.5	101 Would the State agree to the following language? The Business Associate agrees to provide to Covered Entity, within thirty (30) days of vendor's receipt of a written request from Customer, an accounting of Disclosures	See the response to question 72 above.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		of PHI as is required to permit Customer to respond to a request by an Individual for an accounting of Disclosures of PHI in accordance with 45 C.F.R. § 164.528.	
HIPAA Business Associate Agreement 2.14.3	Pg.6	102 Would the State agree to the inclusion of the following language? Covered Entity Responsibilities. Except as expressly provided in the Underlying Agreement or this Agreement, Business Associate will not assume any obligations of Covered Entity under the Privacy Rule. To the extent Business Associate is to carry out Covered Entity's obligations under the Privacy Rule, Business Associate will comply with the requirements of the Privacy Rule that apply to Customer's compliance with such obligations	See the response to question 72 above.
HIPAA Business Associate Agreement 2.15	Pg. 6	103 Can the State agree to this if we add language that this will only be sent when requested by the Secretary?	See the response to question 72 above.
HIPAA Business Associate Agreement 3.4	Pg.6	104 Will the State agree to the following language: The Business Associate will report to Covered Entity any Security Incident, without unreasonable delay, and in any event no more than fifteen (15) business days following Discovery; provided, however, the Parties acknowledge and agree that this Section constitutes notice by	See the response to question 72 above.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		Business Associate to Covered Entity of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below). "Unsuccessful Security Incidents" will include, but not be limited to, pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, Use or Disclosure of PHI. Business Associate's notification to Covered Entity of a Breach will comply with the requirements set forth in 45 C.F.R. § 164.404	
HIPAA Business Associate Agreement 5.	Pg. 9	105 Will the State agree to 15 business days for notifications?	See the response to question 72 above.
HIPAA Business Associate Agreement 5.4	Pg.9	106 Will the State agree to the addition of the following language: With regard to sections 5.1, 5,2 and 5.3, Customer will make such notification to the extent that such limitation, restriction, or change may affect vendor's Use or Disclosure of PHI in connection with the Services, and, with respect to those changes described in this Section 5, Customer shall take all necessary measures to ensure that the	See the response to question 72 above.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		vendor shall not receive any PHI following the date of any changes in or revocation of such permission described in (5.2) or any restriction described in (5.3) and shall assume any liabilities associated therewith.	
HIPAA Business Associate Agreement 6.2	Pg.9	107 Will the State agree to the following language: Upon either party's knowledge of a material breach by the other Party of this Agreement, such Party may terminate this Agreement immediately if cure is not possible. Otherwise, the non-breaching party will provide written notice to the breaching party detailing the nature of the breach and providing an opportunity to cure the breach within thirty (30) business days. Upon the expiration of such thirty (30) day cure period, the non-breaching party may terminate this Agreement. Termination under this section will terminate this Agreement solely as it applies to the Services Agreement giving rise to the material breach.	See the response to question 72 above.
HIPAA Business Associate Agreement 6.3.4	Pg. 10	108 Will the State agree to striking this language?	See the response to question 72 above.
HIPAA Business Associate Agreement 7	Pg.10	109 Will the State agree to this Cost Reimbursement language? Cost Reimbursement. In the event of a Breach	See the response to question 72 above.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		caused solely by Business Associate or its employees or subcontractors and the Privacy Rule and Security Rule require notice to Individuals pursuant to 45 C.F.R. §§ 164.404 and 164.406, Business Associate agrees to reimburse Covered Entity for the reasonable and substantiated costs related to the following: providing notifications to affected individuals, the media, or the Secretary, providing credit monitoring services to the affected individuals, if appropriate, for up to one (1) year, any fines and penalties assessed against Customer directly attributable to a Breach by Business Associate or its employees or subcontractors, investigation costs, and mitigation efforts required under the Privacy Rule or Security Rule. BUSINESS ASSOCIATE'S TOTAL CUMULATIVE LIABILITY IN CONNECTION WITH THIS AGREEMENT IS EXPRESSLY SUBJECT TO THE LIMITATION OF LIABILITY SET FORTH IN THE SERVICES AGREEMENT GOVERNING THE APPLICABLE SERVICE OR PRODUCT.	
HIPAA Business Associate Agreement 7.2	Pg.	110 Will the State agree to including language that specifics that amendments may only be made in writing?	See Pro Forma Contract section D.3.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
HIPAA Business Associate Agreement 7.7	Pg. 11	111 Can the vendor see the proposed methods before agreeing or redlining this section?	See the response to question 72 above.
HIPAA Business Associate Agreement 7.12	Pg. 12	112 Would the state agree to the following language? Compliance in Investigations. The Parties acknowledge that certain breaches or violations of this Agreement may result in litigation or investigations pursued by federal or state governmental authorities of the United States resulting in civil liability or criminal penalties. Each Party will cooperate in good faith in all respects with the other Party in connection with any request by a federal or state governmental authority for additional information and documents or any governmental investigation, complaint, action or other inquiry. Assignment. Neither Covered Entity nor Business Associate may assign this Agreement without prior written consent from the other party, which will not be unreasonably withheld; provided, however, either party may assign this Agreement to the extent that they are permitted to assign the Underlying Agreement. Nothing in this Agreement will confer any right, remedy, or obligation upon anyone other than Covered Entity and Business Associate.	We would consider the first paragraph on Compliance in Investigations but not the second paragraph on Assignment. The State will not be entertaining language changes/additions at this time. All standard language shall remain the same unless otherwise deemed appropriate by the State and will only be considered for the winning bidder.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
HIPAA Business Associate Agreement - Background	Pg.2	113 Would the state consider capitalizing all future instances of: -Use -Disclose -Required By Law So as to conform with their meaning in HIPAA?	The State will not be entertaining language changes/additions at this time. All standard language shall remain the same unless otherwise deemed appropriate by the State.
HIPAA Business Associate Agreement 1	Pg.2	114 Would the state consider including the following definitions? Electronic Protected Health Information" or "Electronic PHI" will have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. § 160.103, as applied to the Electronic PHI that vendor creates, receives, maintains, or transmits from or on behalf of Customer. "Protected Health Information" or "PHI" will have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, as applied to the PHI created, received, maintained, or transmitted by vendor from or on behalf of Customer.	The State will not be entertaining language changes/additions at this time. All standard language shall remain the same unless otherwise deemed appropriate by the State.
A.77.b	Pg.220	115 How much time is the contractor allowed in performing a second physician reconsideration?	This section A.77 of the contract involves the prior authorization process and the Prior Authorization-requesting provider's right to ask for peer-to-peer reconsideration of the Contractor/PBM's initial decision denying the prior authorization request. IMPORTANT: The "reconsideration" process addressed in this section relates to Prior Authorization decisions by the PBM and is not to be confused with the enrollee appeal-related

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
			"reconsideration" process (which results after the enrollee files an appeal contesting the PBM's denial of provider's PA request filed on enrollee's behalf. According to A.77.c., contractor has one business day within which to complete its peer-to-peer reconsideration of its initial denial.
A.77.b	Pg.220	116 How much time is the contractor allowed for the following: 2.The Contractor shall generate a notice to the requestor for all prior authorization request determinations as specified in this Contract and the notice shall include specific reason for denial, including, but not limited to listing preferred agents within the class that have not been tried by the member. If the request requires further escalation or the prescriber requests reconsideration of a denied PA request, the request shall be forwarded to the Contractor's physician for reconsideration and final review. A physician shall review all reconsideration requests for denials and shall be available by telephone at all times for clinical support.	For expedited appeals the contractor is allowed 72 hours to complete reconsideration. For accelerated appeals the contractor is allowed 5 days with an option to request an additional 9 calendar days if more time is needed to obtain medical records. For standard appeals the contractor is allowed 14 calendar days to complete reconsideration.
A.46.d.16	Pg. 147	117 What number of pharmacists and physicians is sufficient?	Winning respondent is responsible to meet contract requirements and should plan accordingly.
Section 1.1a, b, and c	Pg.2	118 Please provide a breakdown of the current estimated lives participating the following programs: • TennCare Program • CoverRx Program	Tenncare Program has 1,199,298 current lives that are pharmacy benefit-eligible out of 1,337,339 total lives CoverRx- Approximately 34,000 lives. CoverKIDS- Approximately 45,000 lives

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		• CoverKids Program	
Attachment 6.6, Section A.5 and A.5.a.1	Pg.52	119 Section 6.6, A.5 and A.5.1 address the Control Memorandum Process relative to the On Request Report (ORR). Can we assume that all ORR and Ad Hoc report requests will be generated by an applicable Control Memorandum? If not, what other documented mechanism prompts an ORR or Ad Hoc report request?	No. An ORR can be sent based on state need by staff associate when asking for the Ad Hoc report.
Attachment 6.6 A44.h	Pg.128	120 TennCare Proprietary and Confidential Information. Would TennCare agree to establish mutual confidentiality provisions?	The State will not be entertaining language changes/additions at this time. All standard language shall remain the same unless otherwise deemed appropriate by the State.
Attachment 6.6 A44.h.1	Pg.128	121 TennCare Proprietary and Confidential Information. Would TennCare consider adding a provision related to "Open Records Requests"? For example: TennCare agrees to give Contractor notice and the minimum statutory or regulatory period of time to oppose or request redactions or limitations on any disclosures under a third party freedom of information or open records request pertaining to this Agreement and/or any proposals related hereto.	The State will not be entertaining language changes/additions at this time. All standard language shall remain the same unless otherwise deemed appropriate by the State.
Attachment 6.6 Section A.44.1	Pg.130	122 In regard to this section…During the transition period will the State provide all TennCare authored and/or developed web content, or will be	The State will provide all content. The State does not make developed changes to the website on a routine basis. We do add documents and links as needed.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		provided by the incumbent? Historically, how often does the State change their developed web content for members for each PBM program, and for providers?	
Section A.42.g. / A.42.h / A.42.i	Pg.144	123 Can the State provide the TennCare claims count for FY 2017-2018? Can the State provide the number of TennCare reversals and adjustments for FY 2017-2018? Can the State provide the number of TennCare Manual Claims processed for FY 2017-2018?	Claims count- See the answer to question #41. FY 2018 Reversals = 4,043,186 FY 2018 Manual claims = 9,737
Attachment 6.6 Section A.52, A. 62, A.82	Pg.52 Pg. 192 Pg. 229	124 If awarded a contract, could the PBM provide to TennCare its PBM PGs reporting format for consideration?	No.
Attachment 6.6 Section A.52, A. 62, A.82	Pg.52 Pg.192 Pg.229	125 Does TennCare or the PBM calculate the performance guarantee payment?	The State will calculate the performance guarantee payment.
Attachment 6.6 Section A.48 Section A.60 Section A.64.	Pg.152 Pg.188 Pg.193	126 Regarding the statement…"The contractor shall establish and maintain a statewide TennCare Program pharmacy provider network…" Can we assume that this statewide provider network includes only those providers/pharmacies that accept the published TennCare reimbursements, and those providers/pharmacies that do not accept these reimbursements will be excluded from the network? Can we assume that	Statewide provider networks include only providers that accept published TennCare reimbursements.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		CoverKids and CoverRx will be at PBM's network rates, and can include pharmacies that may have not accepted the TennCare reimbursement rates?	
Attachment 6.6 Section A.52, A.62, A.82	Pg.161	127 Historically, what percentage of the contractual PGs were passed or failed each month?	NA. The Performance Guarantee is new to this contract.
Attachment 6.6 Section A.56	Pg.171	128 Can the State provide the Cover Rx claims count for CY 2017 and CY 2018 YTD?	No.
Attachment 6.6 Section A.72.b	Pg.198	129 Can the State provide the CoverKids claims count processed by BCBS of TN for CY 2017, and CY 2018 YTD? Can the State provide the number of CoverKids reversals and adjustments for CY 2017, and CY 2018 YTD? Can the State provide the number of CoverKids Manual Claims processed for CY 2017, and CY 2018 YTD?	CY 2017: Paid: 338,188; Reversed: 23,069; Adjusted: 53 1H2018: Paid: 165,904; Reversed: 19,998; Adjusted 7,876 No manual claims in CY 2017 or CY 2018 to date
Attachment 6.6 D.32	Pg.243	130 Any deductible or self-insured retention ("SIR") over fifty thousand dollars ($50,000) must be approved by the State. Is a $500,000 deductible on Workers Compensation acceptable?	See the response to question 72 above.
Attachment 6.6 E.3	Pg.246	131 State Ownership of Goods. The State shall have ownership, right, title, and interest in all goods provided by Contractor under this Contract including full rights to use	See the response to question 72 above.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		the goods and transfer title in the goods to any third parties. Can the State provide a definition of "goods?"	
Attachment 6.6 E.19	Pg.253	132 Notice of Breach Regarding Notice of Breach. Would Will TennCare consider revising "48 hours" to "2 business days?	See the response to question 72 above.
Attachment 6.6 E.21	Pg.253	133 SSA Required Provisions for Data Security Will TennCare be providing social security numbers in the eligibility file?	Yes. However the winning respondent will be required to generate a Member ID for each enrollee on the provided 834 file for the TennCare and CoverKids programs, and will not use the SSN provided.
Attachment A	Pg.261	134 Suggested additional provision: Would TennCare consider an additional provision be added to Attachment A, which follows: Upon receipt from Contractor of reports, statements, and invoices by TennCare or its designee(s), TennCare shall be responsible for promptly reviewing and confirming that the reports, statements, and invoices are accurate and complete and for promptly notifying Supplier in writing of any errors or objections to such reports, statements, and/or invoices. Specifically, this includes but is not limited to all service requests, benefit change requests, pharmacy operations change requests, acceptance tests, quarterly and annual	The State will not be entertaining language changes/additions at this time. All standard language shall remain the same unless otherwise deemed appropriate by the State.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		performance guarantee reports, statements of work, etc. Unless TennCare notifies Supplier in writing of any errors or objections within ninety (90) days from receipt of such report, statement, and/or invoice, all the information contained therein will be deemed accurate, complete, and acceptable to TennCare.	
Attachment A. Item 17 – copay definition	Pg.262	135 As currently phrased this definition is ambiguous. Can this be rewritten to clarify that copay is the amount that "…enrollee should pay" or that "…HCFA should pay?"	Cost Sharing is defined in F&A Rules, section 1200-13-13-.01, which states: COST SHARING shall mean the amounts that certain enrollees in TennCare are required to pay for their TennCare coverage and covered services. Cost sharing includes copayments.
Section C	Pg.	136 Section C. Payment Terms and Conditions Would TennCare consider adding more details around payment of claims, for example: PBM is not required to render payments to Participating Pharmacies or Eligible Members for Claims unless and until PBM has received payment for the Claims from Client. In the event PBM renders Claims payments to Participating Pharmacies and/or Eligible Members prior to receipt of Claims payment from Client, such payments shall not constitute a waiver of any of PBM's remedies with respect to non-payment and shall not establish a course of dealing between PBM and Client.	No.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
Attachment G, Table 1, Requirement 1, Table 3, Requirement 1	Pg.291 Pg.293	137 Please provide the current complete (clean) PA volume.	2017: 1265 2018: 592
Attachment G, Table 1, Requirement 2, Table 3, Requirement 2	Pg.291 Pg.293	138 Please provide the current pended (unclean) PA volume.	2017: 223 2018: 369
Attachment G, Table 1, Requirement 1 & 2; Table 3, Requirement 1 & 2	Pg.219 Pg. 293	139 What volume of prior authorizations are operational (i.e., refill too soon, etc.) versus clinical? What percentage of prior authorizations are received electronically via: web services ePA What volume of prior authorizations requests are initiated via the call center?	-TennCare is unable to delineate Clinical vs. Non-clinical: Total – 2017: 300 Total – 2018: 142 -Web Services ePA: 2017: 59% 2018: 70% -Call Center 2017: 37% 2018: 27% -Fax/Other: 2017: 4% 2018: 3%
Attachment G, Table 1, Question 3	Pg.291	140 Please provide the referenced attestation requirements.	The language in Question 3, Table 1 in Attachment G should read: “Contractor shall provide determination of requested attestations one hundred percent (100%) of the time. Ninety-nine point five percent (99.5%) of attestations with complete information shall be approved or denied with applicable reasons, within ninety-six (96) hours of the time at which it was determined an attestation was needed. This language is amended. (See revised Attachment G.)

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
			See information regarding Attestations on the TennCare/Magellan website.
Attachment 6.6 Section 46.d.	Pg.143 Pg.148	141 Can the State disclose the number of NABD, Appeals and Grievances related to TennCare in FY 2017-2018?	For 2018, there have been 504,217 NABD letters sent through August 2018. See the answer to Question #58 regarding Grievances.
Attachment G, Table 1, Requirement 4	Pg.291	142 Please provide details on the call center volume for CY 2017 and for CY 2018 YTD for: TennCare CoverKids CoverRx	See the answer to Question #69.
Attachment G Table 1, Requirement 4 &5	Pg.291	143 Attachment G table 1, requirement 4 & 5 provide the performance metrics for the TennCare call center. Can the State provide a contract section that details the TennCare program Call Center requirements. Various sections throughout the RFP reference the TennCare Call Center, such as Attachment 6.6, section A.43.c and A.50.b, but they are not supported with the contract detail. The CoverRx and Pharmacy Help Desk requirements in Attachment 6.6, Section A.59 (CoverRx) and Section A.78 (Pharmacy Help Desk) provide more contract detail and requirements for these two programs respectively.	No. See Section A.47, pages 151-152. For CoverRx, see A.55.a.7; page 156.
Attachment G, Table 1, Requirement 4, Table 2, Requirement 3, Table 3,	Pg.291 Pg.292 Pg.293	144 Please provider the required service windows for receipt of calls for TennCare enrollees, e.g. 24/7/365 or other.	24/7/365.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
Requirement 3			
Attachment G, Table 1, Requirement 4, Table 2, Requirement 3, Table 3, Requirement 3	Pg.291 Pg.292 Pg.293	145 Would TennCare consider the following alternative metric? Member calls will be answered in an average of thirty (30) seconds or less by a live agent. Average speed of answer is defined as the time it takes for a live customer service representative to answer the call after option is selected from the front-end IVR. The period of time a call is connected to an IVR system is not included in the measure.	No
Attachment G, Table 1, Requirement 5, Table 2, Requirement 4, Table 3, Requirement 4	Pg.291 Pg.292 Pg.293	146 Would TennCare consider the following alternative metric? Member call abandonment rate will be 2.5% or less. Abandoned calls are defined as calls that have been connected for a minimum of thirty (30) seconds and not answered by a live person before disconnected.	No
Attachment G, Table 1, Requirement 6, Table 2, Requirement 5, Table 3 Requirement 5; Attachment D, item 23	Pg.291 Pg.292 Pg.293 Pg. 284	147 From Attachment D, TennCare Report item 23 'Clinical Initiative Gauge the effectiveness of various clinical initiatives, movement of market share within given therapeutic categories' that is to be provided to the Clinical Director, is this upon request or on a quarterly based upon clinical initiative?	Both. Required quarterly, and upon request via ORR.
Attachment G,	Pg.291 Pg.292 Pg.293	148 From Attachment D, TennCare Report item 35	Quarterly WebEx meetings for purposes of provider education can

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
Table 1, Requirement 6, Table 2, Requirement 5, Table 3, Requirement 5; Attachment D item 35	Pg. 284	'Provider Educator - Demonstrating the nature and extent of educational interventions to outlier prescribers and pharmacists and the clinical and financial outcomes of those interventions:' Would TennCare be amenable to supplementing PBM regional pharmacists (East, Mid, and West) with quarterly WebEx meetings by region, to provide reinforcement of TennCare pharmacy requirements within the State?	definitely be used; however face to face meetings are required by CMS' DUR regulations.
Attachment G, Table 1, Requirement 7; Table 2, Requirement 6, Table 3, Requirement 6	Pg.291 Pg.292 Pg.293	149 The requirement refers to a requirement of "data elements required in the Scope of Work." Can TennCare identify those data elements, and/or provide the referenced Scope of work?	See A.50.b.3, Page 155.
Attachment G, Table 1, Requirement 8 Table 2, Requirement 7, Table 3, Requirement 7	Pg.291 Pg.292 Pg.293	150 Please provide the On Request Reports (ORRs) and report samples that TennCare is receiving today or anticipates will be asking in the future? What format does TennCare receive the reports in today? Is TennCare satisfied with the format of the ORR Reports it is receiving today?	Actual reports will not be provided, however example types of information that has been received via ORR include: Comptroller Audit- request sent to PBM for copies of provider contracts and documentation that LEIE list searches had been completed by the PBM. Often a simple "acknowledgement" report will be requested via ORR—e.g., new convictions sent to the PBM for lock-in assignment, with an acknowledgment that the entry has been completed as an Ad Hoc report via ORR. Another TennCare department needed a listing by NDC and GSN/HSN of all drugs on TennCare's Attestation List and AutoExempt List, which was requested via Ad Hoc report through

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
			an ORR. As an added note, our PBM's Contract Manager has found it to be a valuable way to track requests within TennCare's Team Track system, versus tracking report requests via several other routes: email, verbal, meeting notes, etc. TennCare can receive the Ad Hoc report as requested, or can work with the PBM to determine the report format.
Attachment G, Table 1, Requirement 8, Table 2, Requirement 7, Table 3, Requirement 7	Pg.291 Pg.292 Pg.293	151 Does the current PBM analytical staff generate and deliver reports to TennCare staff, or is it the expectation of the TennCare staff that the PBM automatically generate required reports and analysis via the provided online reporting tool?	Reports required in the contract and via ORR are submitted via the State's Team Tracks tool. The State also reserves the right to request reports verbally, needed with immediacy when required. An example would be when information is needed during the State's Legislative session.
Attachment G, Table 1, Requirement 8, Table 2, Requirement 7, Table 3, Requirement 7	Pg.291 Pg.292 Pg.293	152 Please provide samples of ad hoc reports that TennCare is receiving today or anticipates will be asking in the future?	See the answer to Question #151.
Attachment G, Table 1, Requirement 8, Table 2, Requirement 7, Table 3, Requirement 7	Pg.291 Pg.292 Pg.293	153 Please confirm that all "complete, accurate" ad hoc/ORR reports are predicated on the client providing all specifications for the reports and approving the report deliverable prior to production.	If an ongoing report is to be placed into production for future use, the State will provide specifications and content required.
Attachment G, Table 1, Requirement	Pg.291 Pg.292 Pg.293	154 How many ad hoc reports are typically requested on a quarterly basis?	This depends completely on the business at hand with the State. Content and quantity is variable, and highly dependent upon legislation,

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
8, Table 2, Requirement 7, Table 3, Requirement 7			media requests, audits, benchmarking or other change initiatives as indicated by the state.
Attachment G, Table 1, Requirement 9	Pg.291	155 Table 1, Question 9 identifies various standards that the PBM must achieve. Can TennCare accept a methodology of random claims sampling to measure adjudication system accuracy to satisfy this requirement?	The winning respondent is responsible to meet contractual thresholds. Random sampling is acceptable; however the winning respondent is responsible for claims errors found due to error on their part.
Attachment G, Table 1, Requirement 9.b Table 3, Requirement 8.b	Pg.291 Pg.293	156 On item b, on each referenced table, please define "prescriptive authority." For example: 1. Not sanctioned? 2. Active DEA? 3. DEA schedule check? 4. Provider passed away? 5. Enrolled with state?	Prescriptive authority is defined as having the authority to issue a prescription for prescription drugs. The statement in 9.b. is for the winning respondent to have a prescriber file that does not include taxonomies which do not have prescriptive authority (e.g., chiropractic).
Attachment G, Table 1, Requirement 9.g Table 3, Requirement 8.g	Pg.292 Pg. 293	157 Can TennCare provide the definition of "newly marketed products," and the associated edits that are provided to the PBM associated with newly marketed products?	N/A.
Attachment G, Table 1, Requirement 9.f Table 3, Requirement 8.f	Pg.291 Pg.293	158 Can TennCare provide a list of their non-preferred products that deny at POS without a PA?	All products not preferred will require a prior authorization. Lists will be provided during implementation meetings.
Attachment G,	Pg.291 Pg.293	159 Would TennCare consider the following	No.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
Table 1, Requirement 10, Table 3, Requirement 9		alternative metric? 99.5% POS system availability. Excludes scheduled downtime for maintenance; this standard will not apply when PBM does not have total control over the environment or communication links that impact the process due to third-party involvement.	
Attachment G, Table 1, Requirement 10, Table 3, Requirement 9	Pg.291 Pg.293	160 In regard to the adjudication; If an emergency occurs, what is the acceptable notification requirement defined by contract? Can TennCare also provide a definition of "emergency?"	TennCare's Chief Pharmacy Officer is to be immediately notified during business hours, or if after hours, at the start of the next business day.
Attachment G, Table 1, Requirement 13, Table 3, Requirement 12	Pg.292 Pg.293	161 Please define what TennCare means by 'pharmacy panel' in the context of this PG. Does "appropriate pharmacy panel" mean retail, specialty and if relevant, mail order? Are there other channels such as LTC?	Panel is a list in the PBM's system which will allow the providers listed within to be treated in the same manner. Current provider panels include Ambulatory (retail), Specialty, 340B, LTC, and Physician Dispensaries.
Attachment G, Table 2, Requirement 1	Pg.292	162 Can TennCare provide a definition of "Complete Application," and the identification of the absolutely required data elements required to be considered a complete application?	See CoverRx Website. https://www.tn.gov/tenncare/coverrx.html
N/A	Pg.	163 What are the top ten retail pharmacies (by claim volume) and what percentage of claims is filled at each?	See RFP Amendment 7 Attachment 1 below.
1.1. Statement of Procurement Purpose	Pg.2	164 If an offeror is awarded a contract under RFP #31865-00600, will that offeror, or an affiliate of that offeror under common	The State cannot comment on future procurements and would need to review any responses to a solicitation in accordance with applicable law and the rules, policies, and procedures of

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		ownership, be eligible for subsequent procurement awards relating to pharmacy benefit management, managed care, or other specialized services for the TennCare program?	the Central Procurement Office.
Section 2.1 RFP Schedule of Events	Pg.7	165 Please confirm the correct RFP deadline is November 13th at 12:00pm CST	See Amendment 2 to RFP 31865-00600 Schedule of Events.
Response Form 3.1.1.2	Pg.8	166 Is an offeror permitted to submit the RFP utilizing its proprietary RFP response template for the technical section?	The documentation provided by TennCare per the RFP Template must be utilized when responding. Alternate forms of submission, unless otherwise stipulated within the RFP, will not be accepted.
Response Form 3.1.1.2	Pg.8	167 Is the offeror bound by page limitations for each of the technical response questions, or should the offeror use its own discretion in determining the length of its response to each technical question?	There currently are no page limitations placed upon this RFP. The State does ask that providers refrain from adding documentation that does not relate to the questions specifically asked within the RFP. All RFP guidelines are to be followed.
Cost Proposal Section D-Risk Level for TennCare Program only	Pg.41	168 Will the State confirm that the current PBM vendor is operating under a shared savings or other risk sharing arrangement and the details of the agreement?	Please see the PBM Contracts found here: https://www.tn.gov/content/dam/tn/tenncare/documents2/Magellan.pdf All contracts for the State of Tennessee are available on the State's Website.
Cost proposal & Scoring Guide	Pg.35	169 For the purposes of ensuring the most accurate cost proposal, will the State provide its anticipated membership projections for each of the three programs for the duration of the contract?	See the answer to question #118.
A.7.b.2 Staff Requirements Specific to TennCare	Pg.62	170 For those offerors not currently contracted with the State, will the State confirm that those bidders	See the answer to Question #33.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
PBM Programs		utilizing corporate-located staff on an interim basis to fulfill the required staffing positions be considered to have met the staffing requirements until local, Tennessee staff can be identified?	
CoverRx Pharmacy Services A.55.a.2.(a)	Pg.165	171 In Section 2 of the CoverRx Pharmacy Services Section it states that the Contractor shall "Enroll each eligible individual subject to State's criteria". Please confirm that this portion of the RFP is referring to the Mail in Application forms that the offeror may receive. How will the offeror be made aware of what the State's Criteria is for membership?	CoverRx accepts applications which are mailed in, faxed in and as required by this RFP through an interactive online application. See the TN CoverRx website for criteria for enrollment in the program.
A.44.I.2(f)	Pg.131	172 What is the definition of 'automated overrides'?	There are several types of products that TennCare uses an “auto-lookback” or uses ICD-10 codes transmitted by pharmacy to approve a drug that requires prior authorization. See the TennCare Pharmacy Claims Submission Manual, Section 7.6.1 found on the TennCare/Magellan website.
A.42.d.9	Pg.107	173 Are there situations in which TennCare would allow an override to be placed for emergency situations?	Refer to the TennCare/Magellan website, Pharmacy tab, Program Information tab, Pharmacy Manual, for additional information regarding the 3-day emergency supply.
"A.46.e.5 A.46.e.7"	"Pg.149 Pg. 150	174 It sounds like all prior authorizations have a 24 hour turnaround unless it is member initiated in which the system should calculate a 72 hour turnaround time before sending a denial notice; please confirm. How does this affect the first Performance Metric related to 99.5% of all	The time (24 hours) starts as soon as the provider submits all adequate/complete information in order for a clinician to make a PA decision. Once complete information is received the clinician must render their decision and notify the enrollee in writing within 24 hours. If the PA is initiated by the enrollee the CSR will log a PA request in the system, which generated a fax to the prescriber asking for more

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		complete PA's processed within 24 hours? For this scenario, does the timer start as soon as the provider submits all adequate information in order for a clinician to make a decision?	information. The prescriber has 3 business days to submit the information requested. If the information is not submitted by the prescriber within 3 business days the Contractor shall issue a denial notice to the enrollee within 24 hours.
A.46.e.5	Pg.149	175 If the PA is initiated by the enrollee, and we receive additional information from the provider, do we have 24 hours from the time that information is received?	The Contractor has 24 hours once it receives complete information to make its PA decision and notify the member in writing. The member does not have to receive the notice in 24 hours but written notice must be mailed to the member.
A.46.e.7(b)	Pg.150	176 Is oral outreach only required regarding prior authorizations when a member initiates a prior authorization and the doctor later changes the drug and submits additional information within the 72 hour window? Are there any other scenarios in which oral outreach must be completed to the member, provider or pharmacy when it comes to prior authorizations?	Yes, if the prescriber changes the drug initially requested then the Contractor may orally outreach to the enrollee; however, oral notification must be followed up in written notice to the enrollee. This is the only scenario where oral outreach must be completed.
A.43.b.6(a)	Pg.118	177 What is timely notification? Is this considered when the notification is sent from the system or when the enrollee or provider receive the notification?	Timely notification is the date the enrollee is sent written notification of the Contractor's decision. Ideally, the date the notice is sent from the system is the same date the enrollee is mailed written notification. Once complete information is received by the Contractor to render a decision the notice must be generated and written notification must be mailed to the enrollee. No other scenarios require verbal outreach to the enrollee.
A.46.a.12	Pg.139	178 Please confirm if the offeror conducts a post call survey or maintains an internal audit process, will this suffice for meeting	See A.46.a.12

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		Quality Assurance program requirements?	
A.80.a.6 & 7	Pg.227	179 Please confirm line 7 is a duplication of line 6.	State agrees that reference to A.80.a.6&7 represent a duplication, and section A.80.a.7 of the duplicated clauses is deleted per this RFP Amendment as seen below.
Definitions and Acronyms	Pg.265	180 Will the State provide additional details on the expectations or existing program design for the lock in and audit process by the clinical pharmacists for each program?	Yes, during implementation meetings.
A.42.f	Pg.113	181 The Contractor shall assure that the TennCare-POS systems allows pharmacists to execute an emergency override that shall process an emergency seventy-two (72) hour supply of drugs in normally covered therapeutic categories that are non-preferred or would otherwise require prior authorization. Emergency overrides- 72 hour supply- does this process include non-formulary drugs?	The State does not refer to drugs being "non-formulary". Please refer to the TennCare/Magellan website, Pharmacy tab, Program Information tab, Pharmacy Manual, for additional information regarding the 3-day emergency supply.
A.46.a	Pg.137	182 Contract references "A clinical pharmacist shall be on duty twenty-four (24) hours a day, seven (7) days a week (24/7). The PA Unit shall have the capacity to render written and oral clinical decisions in response to provider requests for PA (and in response to provider requests for Contractor to reconsider an adverse PA decision) on a 24/7 basis." Does the PBM need to orally notify the prescriber or member of every	A.46.a. is regarding the TennCare Pharmacy Program. The CoverRx program does not require prior authorizations. See A.46.a. "In accordance with 42 CFR §§ 438.3(s)(6), and 438.210, Contractor must notify the requesting provider of its PA determination, and, if the PA is not approved, issue a Notice of Adverse Benefit Determination (NABD) to the enrollee on whose behalf PA was requested, within (24) hours of receiving all of the information necessary to facilitate the determination."

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		decision across all lines of business listed in the proposal?	
A.46.b	Pg.140	183 Contract references "If the request is not consistent with applicable PA criteria, the request shall be referred to a clinical pharmacist in the PA Unit. If upon review, the clinical pharmacist finds sufficient justification for an override, the request and clinical rationale for the outcome shall be documented and an override entered in the TennCare-POS system." Please define sufficient justification for an override in lieu of approving an authorization. What is the expectation for the length of the override?	The Clinical Pharmacist may be able to determine that coverage is appropriate within the criteria that the pharmacy technician could not determine using decision trees within the winning respondent's P.A. system. We would expect that the Clinical Pharmacists would make a thorough check of the enrollee's medical history available in the respondent's system and a thorough check of the enrollee's drug history and the State's Controlled Substance Monitoring Database (PDMP) if the request is for a controlled substance. The expectation for the length of override would be that an approval for the appropriate length of time for the product requested is entered.
A.42.f	Pg.114	184 TennCare Emergency Supply Copays – The enrollee shall not be charged a copay for the emergency supply. The emergency supply shall count against the monthly prescription limit. What is the monthly prescription limit for CoverKids?	There is no prescription limit for CoverKids
C.1	Pg.26-27	185 Is the current PBM vendor obligated to provide services to any new PBM vendor under a defined transition period? If so, what are the services the current PBM vendor is obligated to provide?	All contracts for the State of Tennessee are available on the State's Website. Please refer to the current PBM contract: https://www.tn.gov/content/dam/tn/tenncare/documents2/Magellan.pdf
C.2	Pg.27	186 Will the State provide the current communication protocols and formats preferred when interacting with the MMIS?	Yes. This will be provided to the winning respondent during implementation meetings.
C.2	Pg.27	187 At what level is the	Since TennCare's pharmacy program

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		current vendor required to interact with the current MCOs providing physical health to TennCare enrollees?	is carved-out from the MCO's, TennCare is not subject to new CMS guidelines that require the MCO DUR data to be incorporated into TennCare data. However the winning respondent will be very involved with the MCO pharmacy and quality teams in assisting with reports and other data which may be required.
C.3	Pg.27-28	188 Does the State have requirements to supply data in a digital format [i.e. to an enrollee's cellphone via an app?	Not at this time for all TennCare Pharmacy Programs.
C.14	Pg.31-32	189 At what level does the department wish to have decision support availability. Does the department wish to have availability at a reporting level, data query level, or access to the data model with TennCare's own query and reporting tools?	All three of the suggested methods in this question will be required. TennCare requires access for pharmacy and other departmental staffs to the winning respondent's reporting tools and programs. This may involve using the tools to query data, to run pre-programmed reports, and to have the ability to save reports that can be called time and time again. TennCare also requires access with our own query tools to the winning respondent's data warehouse. TennCare requires that all data elements that are described in A.50.b.3., Page 155, are available via the winning respondent's reporting tools and programs and data warehouse accessible with TennCare's reporting tools.
C.16	Pg. 32	190 Is TennCare in discussions with any other states for a purchasing coalition? If so, what states?	This does not relate to the current PBM and would be considered an internal process that is not disclosed to outside providers.
C.16	Pg.32	191 Would other states need to have a contract with the PBM awardee or does TennCare envision an umbrella organization over	The intent of this RFP is to award to one provider.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		multiple PBMs to negotiate purchasing?	
A.2.e	Pg.50	192 What Optional PBM Services does the State envision it might use in the future?	The State does not comment on its process of future procurements/strategic planning.
3.3.7	Pg.10	193 If a different prime contractor decides to submit a response with one of our services as a subcontracted service, without our knowledge, would we be disqualified?	Per 3.3.7 of the RFP: A Respondent must not submit a response as a prime contractor while also permitting one or more other Respondents to offer the Respondent as a subcontractor in their own responses. Such may result in the disqualification of all Respondents knowingly involved. This restriction does not, however, prohibit different Respondents from offering the same subcontractor as a part of their responses (provided that the subcontractor does not also submit a response as a prime contractor).
A.8.b.3	Pg.67	194 Please confirm when offeror submits materials for approval, we would provide the final version; thus, there would be no need to re-submit the PDF version? If a final product is required to be provided to the State, is there a requirement on how these are sent to TennCare? USPS, overnighted, etc?	See section 3.3 Response & Respondent Prohibitions in response to the first part of the question. See section 3.2 Response Delivery for the second part of the question.
A.8.b	Pg.67	195 In regards to the 200 word limit, has the State considered situations such as information on approved Formularies where it may be difficult to consolidate information into 200 words or less? If the offeror anticipates a material will be over 200 words, would the offeror have the ability to request approval ahead of the approval submission?	Per section A.8.b.: Articles and/or informational material included in written materials such as newsletters, brochures, etc. shall be limited to approximately 200 words for purposes of readability **unless otherwise approved in writing by TennCare.**

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
A.8.b.4	Pg.67	196 Materials may require updating for various reasons; annual updates, logo change, program change, etc. Will offerors be permitted to include the reason for modifying a previously approved version in our submission for approval after the materials have been updated?	All adjustments would need to be submitted to the State in writing prior to approval.
A.48.b.	Pg. 152	197 The State refers to the ability for the State to request the establishment, maintenance and administration of a MTM program, however, the State does not request any information related to the vendor's capabilities. Would the State propose that each vendor include their experience and approach in the technical response for the State to make an informed decision for future MTM programs?	As noted in A.48.b. TennCare MTM Pilot Program., this will be by contract amendment upon request. See Section 3.1.1.3 in the RFP response requirements where it states: "Any information not meeting these criteria will be deemed extraneous and will not contribute to evaluations."
A.10.	Pg. 70	198 Section A.10 references MTM and specialty PBM services. Knowing that the State is interested in the possibility of MTM services in the future and since specialty drugs services were included in the same sentence as an example, it could be inferred that the State could be interested in specialty drug management, as well. Would the State propose that each vendor include their approach to managing specialty drug utilization and specialty drug spend in the technical response?	See Section 3.1.1.3 in the RFP response requirements where it states: "Any information not meeting these criteria will be deemed extraneous and will not contribute to evaluations."
Section C.9	Pg. 30	199 The requirement states	This question is referring to the

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		"Describe in detail how the Respondent proposes to meet all of the CoverKids requirements in the pro forma contract." Does this refer to the CoverKids Formulary requirements only (pro forma Section A.73) or the CoverKids pro forma requirements in their entirety (pro forma Sections A.63 through A.82)?	CoverKids Formulary requirements only.
C.13	Pg. 31	200 Can you please state any requirements you have that are specific to Medispan data (beyond Medispan AWP), including impacts on POS edits, reporting, and extracts?	TennCare's current PBM vendor uses the FDB database. The State has used both FDB and MediSpan in the past, and our preference is MediSpan. If FDB is used, the State requires the MediSpan's GPI (Generic Product ID) field included in the drug file and in the claims file. It would also be necessary to include the AWP values from the MediSpan database.
C.13	Pg. 31	201 Does TennCare prefer specific MediSpan drug product characteristics over what is available in FDB?	See the answer to Question #200.
C.13	Pg. 31	202 RFP Section C.13 instructs Respondents to describe how their "drug reference database will meet TennCare's needs." Will TennCare please define its needs relative to the drug reference database in more detail in order to assist Respondents address this in their responses?	See the answer to Question #200. TennCare's pharmacy staff has used proprietary queries and macros to mine data which is based on MediSpan's GPI and rollups of the GPI. We also have found it much simpler to use the 14-digit GPI code with its built-in logic vs. using GCN, GSN, HSN, HIC3 and HICL codes for drug categorization which have no logic and each must be looked up every time.
RFP Attachment 6.7, Bidder's Library Item (2)	Pg. 304	203 CoverKids Sample Reports Template provides enrollment and other numbers from 2016. Would the State please provide updated enrollment numbers?	See the answer to Question #118.
A.43.e, Paragraph #1	Pg. 121	204 How far back does	1Q1991

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		TennCare's outstanding Balance go? Is it all electronic? If it is not all electronic, is the contractor expected to also maintain the non-electronic data?	1Q1991 - 4Q2000 - Microfiche Yes, the winning respondent shall maintain non-electronic data
A.43.e, Paragraph #4	Pg. 132	205 Regarding past due notifications, the requirement states "Notifications shall be issued within 5 days of delinquent date for supplemental rebates." Is the State's definition of delinquent date the date of the past due notification (i.e., 45, 75 or 90 days) making the due date 50, 80, or 95 days? This only references supplemental rebate but this requirement looks to be for all rebate programs (federal, supplemental, diabetic supply, CoverRx, and CoverKids). Please confirm.	Recognizing that each respondent uses different systems for rebate management, The State will renegotiate this schedule during implementation meetings.
A.46.a.4	Pg. 138	206 Section A.46.a.4 references noticing enrollees of PA decision notices, whether the PA is approved, partially-approved or denied. Other sections only speak to noticing enrollees with a NABD when PA requests are denied. Please confirm enrollee notices are to be sent regardless of outcome of PA decision.	Enrollees need to be notified by Contractor of PA decisions for PAs sought during the appeal process. Currently, TennCare Solutions Unit notifies enrollees of approval when PA is sought and approved during the appeals process. The aim is to get away from TennCare notifying the enrollee of an approval after an appeal is filed and instead have the Contractor notify the enrollee of approval.
A.42.d.13	Pg. 108	207 In Section A.42.d.13 of the Pro Forma Contract that describes when TPL is detected on the date of service, is the State referring to all claims with a date of service and adjudication date after the OHI segment is discovered	The State is not seeking subrogation services. The State expects that the winning respondent will provide an online, real-time TPL solution that will deny claims with NCPDP denial code “41” at the POS, and pharmacy will then be provided with information on the primary payor via a supplementary message, so the pharmacy can submit

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		and loaded into the system, or is a subrogation service being requested?	the claim first to the primary payor and then any remainder to the winning respondent for payment consideration.
Attachment C, Item 37	Pg. 278	208 In the Liquidated Damages Section, Attachment C, Item 37, there is a sentence that states "If the Contractor allows a claim(s) to be adjudicated with TennCare as the sole payor when Other Insurance existed, and the valid TPL segment is not found on the Contractor's TPL file, but is found on the State's TPL file. Liquidated Damages in the amount of up to 10% of the amount paid to pharmacy by the State." Is this statement contingent upon the State providing their TPL file to the contractor?	Yes. TennCare will share its TPL file with the winning contractor per this instance.
Attachment A, Definitions	Pg. 264	209 "Attachment A provides a definition of First Fill Date which states ""For purposes of determining when the Contractor is entitled to receive a TPL Fee for POS Actual Cost Avoidance savings, the term ""first fill date"" shall mean the day on which the new TPL information provided by the Contractor's POS system to the pharmacy attempting to fill an enrollee prescription results in a NCPDP Code 41."" As the RFP states that the Contractor will receive no TPL fees outside of the admin fee, is the definition not applicable to the procurement?"	Definition is not applicable to the RFP and will be removed in Amendment 7 to the RFP.
C.9	Pg. 29	210 Please confirm the PDL	The disruption analysis should be

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		disruption analysis should be performed on the TennCare program only.	performed on the TennCare program only.
3.1.1.2	Pg. 8	211 Please confirm that Respondents may submit tables and graphics in a font size smaller than 12-point font as specified in RFP Section 3.1.1.2.	As long as the submission is legible and all data points can be read, font smaller than 12 is acceptable.
3.3	Pg.	212 Is TennCare aware that Rusty Hailey, TennCare's Chief Pharmacy Officer until August of 2018, is now employed by Change Healthcare, an anticipated respondent to RFP 31865-00600 (the "RFP"), as its Vice President Medicaid Pharmacy Services?	The Central Procurement Office is reviewing this matter, in accordance with its Business Conduct and Ethics Policy 2013-009.
3.3	Pg.	213 Did Mr. Hailey, through his recent employment with TennCare, have access to proprietary or confidential TennCare information relating to the RFP that is not available to the public or other respondents and that would assist a respondent in responding to a solicitation or in obtaining a contract with TennCare?	See answer to question 212 above.
3.3	Pg.	214 Does TennCare consider Mr. Hailey's former employment with TennCare and current employment with Change Healthcare as potentially providing Change with an "Unfair Competitive Advantage," as that term is used in the Central Procurement Office Business Conduct and Ethics Policy and Procedures (the "Policy")?	See answer to question 212 above.
3.3	Pg.	215 Has TennCare notified and/or does TennCare intend to notify the Chief	See answer to question 212 above.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		Procurement Officer of the potential "Organizational Conflict of Interest" associated with Mr. Hailey's past and present employment?	
3.3	Pg.	216 Has TennCare provided and/or does TennCare intend to provide the Chief Procurement Officer with a plan to Avoid, Mitigate, or Waive, as those terms are used in the Policy, any conflict associated with Mr. Hailey's past and present employment?	See answer to question 212 above.
3.3	Pg.	217 Will Change Healthcare be asked to provide a sworn statement or attestation that Mr. Hailey has not and will not work on any submission by Change Healthcare related to the RFP and that Mr. Hailey has not and will not share with Change Healthcare any information that Mr. Hailey received regarding the RFP while working for TennCare?	See answer to question 212 above.
A.46.a.15.b and A.46.e.8	Pg.140 Pg.150	218 Abandonment Rate: Please confirm whether TennCare allows Contractor to exclude calls that abandon within the first 30 seconds, to account for callers who may have misdialed.	Yes, misdials and dropped calls are excluded from abandonment rate calculation.
A.46.a.8	Pg. 138	219 Notification of system outage: In the event of a claim or call center outage that occurs during a weekend/holiday/afterhours , will Contractor be provided with contact information to provide notification outside TennCare's normal	TennCare's Chief Pharmacy Officer is to be immediately notified during business hours, or if after hours, at the start of the next business day. Winning Respondent will be provided contact information for TennCare's pharmacy staff during implementation meetings.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		operating hours? Or would TennCare's expectation be that Contractor notify TennCare during normal working hours.	
C.1	Pg. 31	220 Will the State please tell vendors where the set of federal requirements for enterprise content management (ECM) systems" may be found?	Per the MECT Checklists, the set of federal requirements for enterprise content management (ECM) systems may be found in the following documents: MITA 3.0 Part III, Ch5 Application Architecture; and Content Management Interoperability Standards
1.1, Statement of Procurement Purpose b. Cover Rx Program (CoverRx) AND c. CoverKids Program (CoverKids)	Pg.2	221 Does CMS recognize CoverRx as a State Pharmaceutical Assistance Program (SPAP)? Language: b. CoverRx Program (CoverRx): The State's pharmacy assistance program . . . c. The federal Social Security Act Title XXI Children's Health . . .	Regarding CoverRx, see the answer to Question #62. CoverKids is TN's standalone CHIP Program, recognized by CMS, and funded with Title XXI dollars.
1.1, Statement of Procurement Purpose, c. CoverKids Program (CoverKids)	Pg.2	222 In order to estimate the level of effort for all requirements, the vendor needs to be able predict the expected volumes of services to be provided. Therefore, would the State please provide expected enrollment levels for TennCare, CoverRx, and CoverKids? Additionally, could the State please provide current utilization statistics for each program? Language: The federal Social Security Act Title XXI Children's Health . . .	Covered lives--See the answer to question #118. Claims volume—See the answer to question #41.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
1.1, Statement of Procurement Purpose, c. CoverKids Program (CoverKids)	Pg.2	223 Could the State please provide current and expected volumes of the clinical, technical, and member call centers as well as current claim volumes for each of the three populations? Language: The federal Social Security Act Title XXI Children's Health . . .	Claims volume, see the answer to Question #41. Call center volume see the answer to Question #69.
3.1.2.	Pg.8	224 Would TennCare allow us to use smaller point font for ancillary text in elements such as figures, tables, and subtitles? Language: 1. A response should be economically prepared, with emphasis on completeness and clarity. A response, as well as any reference material presented, must be written in English and must be written on standard 8 ½" x 11" pages (although oversize exhibits are permissible) and use a 12 point font for text. All response pages must be numbered.	As long as the submission is legible and all data points can be read, font smaller than 12 is acceptable. See the answer to Question #211 above.
3.3.8	Pg.11	225 Does this section prohibit a response that contains, as key staff, an individual who is, or within the past six (6) months has been, a State employee? Language: 2. The State shall not consider a response from an individual who is, or within the past six (6) months has been, a State employee. For purposes of	All responses to this RFP must be made in accordance with applicable State law, rules, and the Policies and Procedures of the Central Procurement Office.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		this RFP . . .	
C.7.	Pg.21	226 What are the current claim submission requirements to identify 340B claims for FFS claims? Are pharmacy providers required to identify through NCPDP fields (409-DN Ingredient Cost Submitted), 420-DN (Submission Clarification Code) and/or 423-DN (Basis of Cost Determination)? Are physician-administered drug claims (HCFA1500, UB92) required to be submitted with modifiers such as JG, TB or UD? What are the current claim submission requirements to identify 340B claims for MCO claims? Are pharmacy providers required to identify through NCPDP fields (409-DN Ingredient Cost Submitted), 420-DN (Submission Clarification Code) and/or 423-DN (Basis of Cost Determination)? Are physician-administered drug claims (HCFA1500, UB92) required to be submitted with modifiers such as JG, TB or UD? Language: Describe your experience and expertise in working with 340B covered entity providers and 340B claims with other Medicaid agencies. Describe your capabilities to allow 340B covered entities to flag claims that have been	340B Covered Entities are required to submit all claims that are purchased via the 340B Pricing Program using the following: a) 340B pharmacies are required to identify 340B claims by submitting the Submission Clarification Code (Field 420-DK) of "20" b) 340B pharmacies are required to identify 340B claims by submitting the "Basis of Cost Determination" (Field 423-DN) of "08" for "Disproportionate Share Pricing". c) 340B pharmacies are required to submit their 340B Acquisition Cost in the "Ingredient Cost Submitted" (Field 409-D9) and their Usual and Customary Cash Price in the "Usual and Customary Charge" Field (Field 426-DQ). 340B claims from MCO require a claims modifier along with all physician-administered drug claims.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		submitted with 340B pricing, and those that have not, and your experience in working with Labelers to submit non-340B claims from covered entities for federal rebates. Include any experience you have had with other states in handling claims from 340B contract pharmacies, and how you have worked with covered entities to ensure no discount duplication occurs. If a 340B covered entity using a virtual 340B model submits a partial quantity for a prescription that was purchased with 340B discount pricing and the replacement product is not available with 340B discount pricing, or vice versa, how will Respondent's system handle this scenario?	
Attachment 6.2, C.5.	Pg.28	227 Please provide paid claims volume for TennCare, CoverRx and CoverKids (approximate) separated out by plan. Language: Describe how the your claims adjudication/processing system will	See the answer to question #41.
A.2.e.	Pg. 50	228 Please identify by name any additional State program that Contractor may be requested to provide PBM services. For each program identified, please provide a member count and identify the source of funding (e.g, State-only, State-Federal, etc.)	This RFP is for services for TennCare, CoverRx and CoverKids only. Source of funding: TennCare- State and Federal CoverKids- State and Federal CoverRx- State only For member count, see the answer to question #118.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		Language: Optional PBM Program Services (Optional Services)	
Attachment 6.6, A.42.a.	Pg. 101	229 Please provide the volume of claims processed annually for FFS and MCO. Language: TennCare POS System Overview . . .	TennCare's pharmacy program is carved-out from the MCO's, so there are no MCO pharmacy claims. See the answer to question #41.
A.42.b.1 TennCare Weekly Claims Payments	Pg.102	230 Does the Contractor issue payments to the providers from its own bank account or is there a State funded bank account that is used for such payments? Language: The Contractor shall issue payments to Pharmacy Providers each Friday. In order for the State to be able to fund weekly pharmacy provider payments the Contractor must follow a schedule outlined by the TennCare Accounting Office.	The Contractor will issue payments to Providers from a Contractor owned bank account for all TennCare Pharmacy Programs.
A. 42.b.3, TennCare Weekly Claims Payments	Pg.102	231 What is process/rules of provider payment in event MCO does not wire payment to Contractor according to the schedule (Thursday)? Should the related MCO claims be withheld from payment to provider? Language: The State shall pay each MCO directly for their pharmacy spend (total of ten invoices). In turn, each MCO will pay these funds to the Contractor. The weekly payment schedule works as	If the MCO wire payment fails to reach the Pharmacy Contractor by 1:00 pm on Thursday, the Contractor shall reach out to TennCare Accounting and directly to the MCO to request a status on the wire. If the wire does not arrive by 12:00 noon on Friday, the Contractor shall request permission from TennCare Accounting to hold payments until the following business day.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		follows:	
A.42.d.7	Pg. 106	232 Please provide TennCare's 340B claim rules. Language: TennCare 340B Claims - The TennCare POS system shall capture, edit and adjudicate pharmacy claims as necessary to support TennCare's 340B claim rules, as well as support a customized pharmacy Network of 340B providers…	340B Covered Entities are required to submit all claims that are purchased via the 340B Pricing Program using the following: a) 340B pharmacies are required to identify 340B claims by submitting the Submission Clarification Code (Field 420-DK) of "20" b) 340B pharmacies are required to identify 340B claims by submitting the "Basis of Cost Determination" (Field 423-DN) of "08" for "Disproportionate Share Pricing". c) 340B pharmacies are required to submit their 340B Acquisition Cost in the "Ingredient Cost Submitted" (Field 409-D9) and their Usual and Customary Cash Price in the "Usual and Customary Charge" Field (Field 426-DQ). 340B claims from MCO require a claims modifier along with all physician-administered drug claims.
A.43.b.1.	Pg. 118	233 Are the actual results from the pharmacoeconomic modeling presented to the TennCare Pharmacy Advisory Committee or just the pharmacoeconomic review criteria? If the actuals results are presented, is information regarding rebates (Federal and/or supplemental) withheld or presented? Language: The Contractor shall develop and present to the TennCare Pharmacy Advisory Committee the clinical and pharmacoeconomic review	Historical presentation packets presented at TennCare's PAC meetings are available on the TennCare/Magellan website. Go to the Committee Tab, PAC Committee, for examples. URL is in the bidder's library, but for ease of reference: https://tenncare.magellanhealth.com/tenncare_portal/spring/main?execution=e1s2 . In addition, it should be noted that the Review Packet subsection is located ¾ of the way down the page and requires user to scroll down.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		criteria the Contractor used to make recommendations regarding preferred and non-preferred drugs and the specific written guidelines/criteria to be used in the administration of the prior authorization of non- preferred drugs.	
A.43.e	Pg. 121	234 Please identify each TennCare PBM Program for which Contractor will be required to manage rebates. Language: The Contractor shall process, invoice and collect federal (OBRA, CMS) and supplemental rebates through the Contractor's rebate administration systems, and shall assume all responsibility for uncollected receivables for each TennCare PBM Program at Go Live for each program.	Federal and Supplemental rebates for the TennCare Pharmacy Program. Commercial rebates to be managed also for the CoverRx and CoverKids programs.
A.43.e	Pg. 121	235 For each TennCare PBM Program for which Contractor will be required to manage rebates, please identify the current total amount of uncollected receivables by rebate quarter. In regard to uncollected rebate receivables, please confirm that the Contractor will only assume responsibility for the collection thereof and will not assume responsibility for paying the actual debt. Language: The Contractor shall process, invoice and collect	TennCare: FFS - uncollected Rebate receivables for 1Q2016 - 1Q2018 is $15,593,157. MCO - uncollected Rebate receivables for 1Q2016 - 2Q2018 is $10,421,520 Supplemental - uncollected Rebate receivables for 1Q0216 - 2Q2018 is $12,041,151 Diabetic Supply - uncollected Rebate receivables for 1Q2016 - 1Q2018 is $209,535 Regarding uncollected Rebate receivables, winning respondent will be responsible for collection of rebates. CoverRx- None CoverKids- see the answer to Question

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		federal (OBRA, CMS) and supplemental rebates through the Contractor's rebate administration systems, and shall assume all responsibility for uncollected receivables for each TennCare PBM Program at Go Live for each program.	#277.
A.43.e	Pg. 121	236 Is all the historical data that the Contractor will receive in an electronic format? If not, please identify by rebate quarter, program (e.g., Federal, Supplemental, MCO) and data type (e.g., claims, invoices, payments, disputes) the historical data that will be provided in an electronic format and the historical data that will not be provided in an electronic format. Language: The Contractor shall import historical quarterly rebate data into their rebate management system, provided by the State's current rebate vendor.	TennCare has approximately 30 cases of microfiche data from prior to 2001q4 that we would want to be housed by the winning respondent. In addition to the 30 microfiche cases housed at TennCare, there are at least 50 boxes in the PBM's Richmond, VA Iron Mountain storage.
A.43.e	Pg. 121	237 For historical data, will invoice data be provided by rebate quarter / program / NDC and include original invoice records and prior quarter adjustments? If not, please explain or provide the layout of the invoice data that the Contractor will receive. Language: The Contractor shall import historical quarterly rebate	Yes

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		data . . .	
A.43.e	Pg. 121	238 For historical data, will dispute status information (e.g., resolved, unresolved) be provided? If not, please explain how the status of a dispute will be conveyed to the Contractor. If so, will dispute status information be provided by rebate quarter / program / NDC? If not, please explain or provide the layout of the disputes status information that the Contractor will receive. Language: The Contractor shall import historical quarterly rebate data . . .	All available data from the incumbent will be provided as stated in the question.
A.43.e	Pg. 121	239 Will all historical data look the same or is it expected that the Contractor may see different variations/formats of data (due to historical rebate vendor changes)? For example, the Contractor might see data represented one way from 1991-1998 and then represented another way 1999 and forward. Language: The Contractor shall import historical quarterly rebate data . . .	Historical data will probably look different than today's data and changes over time. See question #236 above.
A.43.e	Pg.121	240 Will the Contractor be required to take ownership of any paper rebate documentation from the current rebate vendor? If so, approximately how	See the answer to Question #236.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		many boxes of rebate documentation will the Contractor be required to take and where (city and state) is it currently located? Will the Contractor be required to assume any costs of transferring paper documents from the current rebate vendor or will the current rebate vendor be responsible for any costs? Language: The Contractor shall import historical quarterly rebate data . . .	
A.43.e	Pg.121	241 Please provide the layouts for the data that the Contractor will be required to provide to designated State staff. Language: The Contractor shall provide the designated State staff data files that contain the specific information and in the specified format as required by the State.	Layouts will be provided to the winning respondent during implementation meetings.
A.43.e	Pg.121	242 Please provide the quarterly rebate invoice volume for each TennCare PBM Program for which Contractor will be required to manage. Does the current rebate vendor use another method of delivery other than the U.S. mail (e.g. manufacturer portal)? If so, approximately how many invoices are distributed electronically vs. paper mailing? Are any specific programs, e.g. CHIP, ADAP, invoiced	For TennCare, see the answer to Question #30. U.S. Mail and Electronic Invoice Delivery is currently used. Approximately 96 paper mailings were made. Programs invoiced separately are: FFS, MCO, Supplemental and Diabetic supply. No.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		separately? Are any specific programs other than Title 21 CHIP, excluded from invoicing? Language: The quarterly rebate invoices shall be generated for all pharmaceutical manufactures and State approval by thirty (30) days after the receipt of the quarterly CMS file for supplemental rebates and by sixty (60) days for federal rebates.	
A.43.e	Pg. 121	243 Are applicable mailing costs for mailing invoices to Drug Manufacturers handled as a pass-through cost to the State? Language: The quarterly rebate invoices shall be generated for all pharmaceutical manufactures and State approval by thirty (30) days after the receipt of the quarterly CMS file for supplemental rebates and by sixty (60) days for federal rebates.	We anticipate that there will be electronic options for many drug manufacturers for receiving invoices for rebates. Any additional mailing cost will not be paid as a pass-through by TennCare.
A.43.e	Pg.121	244 Does this requirement mean invoices are to be delivered 30 days after receipt of the CMS file and 60 days after the end of the quarter? If so, does this requirement apply to both supplemental rebates and federal rebates? If not, please explain. Language: The quarterly rebate invoices shall be generated	The Quarterly Rebate Invoices will be generated for all pharmaceutical manufactures and TennCare approval by thirty (30) days after the receipt of the quarterly CMS file for Supplemental Rebates. The Quarterly Rebate Invoices shall be generated for all pharmaceutical manufactures and TennCare approval by sixty (60) days after the receipt of the quarterly CMS file for Federal Rebates.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		for all pharmaceutical manufactures . . .	
A.43.e	Pg.121	245 Is MCO utilization invoiced in aggregate or separately from Fee-For-Service utilization? If separately, is the MCO utilization invoice in the aggregate or separately by each MCO? If invoiced separately, how many MCO's utilization is invoiced for rebates? Language: The quarterly rebate invoices shall be generated for all pharmaceutical manufactures . . .	See the answer to Question #30.
A.43.e	Pg. 121	246 Is the MCO utilization eligible for supplemental rebates? If so, is the MCO utilization invoiced separately from the fee-for-service (FFS) utilization? If the MCO utilization is invoiced separately, is all MCO utilization aggregated for invoicing or is each MCO's utilization invoiced separately? Language: The quarterly rebate invoices shall be generated for all pharmaceutical manufactures . . .	Supplemental rebates do not apply to MCO utilization.
A.43.e	Pg.121	247 Are medical providers required to include NDCs on claims when billing procedural terminology codes that are associated with drugs? Language:	Yes.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		The Contractor shall accept medical claims data from the State including but not limited to, current procedure terminology codes, in a format mutually agreed upon by both parties, and shall submit paid claims for physician-administered drugs for federal and supplemental (if applicable) rebates.	
A.43.e	Pg.121	248 Are medical claims identified as 340B at the claim level? If so, what fields are used by the provider to flag them as 340B? If not, how is 340B utilization from medical providers identified for exclusion from rebates? Language: The Contractor shall ensure that claims received and paid from pharmacies contracted as 340B providers, are not submitted for federal rebates if such claims are flagged as 340B claims	The flagging of 340B claims is referring to pharmacy claims, using the two appropriate NCPDP fields to indicate that the claim was filled using drugs that were acquired with the Covered Entity's 340B discounted price. It does not refer to medical claims.
A.43.e	Pg.121	249 What methodology is currently used by the current vendor for identifying 340B providers for rebate administration purposes? Does the current vendor use any other source to identify 340B entities? How does the State currently identify out-of-state providers identified as 340B? Language: The Contractor shall ensure	Any pharmacy with an NPI listed on HRSA's website as a Covered Entity is identified as a 340B provider. Out-of-state 340B providers would have to be within 50 miles of the border of the State of Tennessee, and we currently do not have any of these pharmacies in our network.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		that claims received and paid from pharmacies contracted as 340B providers . . .	
A.43.e	Pg.121	250 Are applicable mailing costs for mailing written notifications to Drug Manufacturers handled as a pass-through cost to the State? Language: The Contractor shall ensure that written notifications are sent to Drug Manufacturers concerning past-due rebate payments for undisputed account balances.	No. Applicable mailing costs for mailing written notifications to Drug Manufacturers are not handled as a pass-through cost to the State.
A.43.e	Pg.121	251 Is the 90 day requirement limited to supplemental rebates only? Does this requirement include only new disputes, or does it include inherited disputes as well? For inherited disputes, is there a specific timeframe allowed for inherited disputes from the current vendor? What is the total volume of outstanding disputes for all programs? Language: Dispute resolution pertaining to units billed for supplemental rebates shall be done by the Contractor based on unit resolution performed on CMS Rebates. The Contractor shall perform all dispute resolution activities with pharmaceutical manufacturers pertaining to supplemental rebate	Dispute Resolution Proposal for Federal & Supplemental Rebates shall be settled within ninety (90) days of dispute. State will work with the winning respondent during implementation to determine feasible timeframe for resolving historical disputes. 90 Days Aged Disputes for all programs = 238. 150 Days Aged Disputes for all programs = 304 240 Days Aged Disputes for all programs = 584

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		calculations and collections. The Contractor shall present for State approval remedies for all disputes within ninety (90) days of dispute. The State shall have final approval of all settlements negotiated.	
A.43.e	Pg.121	252 Will the Contractor be required to maintain a lockbox for the State? If so, will deposits for TennCare Rebate Program, CoverRx and CoverKids be deposited into the same account, or would there be different accounts for each program? Would the various programs covered by TennCare Rebate Administration (FFS, MCO, Supplemental, Diabetic Supplies) require separate lockbox accounts? If the State maintains the lockbox, will the Contractor have access to facilitate payment entry? Language: One hundred percent (100%) of all monies collected on behalf of the State shall be remitted to the State. The Contractor agrees that all rebates collected on behalf of the State shall be collected for the sole benefit of the State's share of costs, and that no other monies other than rebates shall be collected based on the State's program	There are only two separate lock boxes that are maintained and paid for by the State. These lock boxes deposit into a state bank account. The contractor has web access to all contents of the lock box. They are for TennCare Medicaid drug rebates only- Supplemental and Other. Contents of the lock boxes are reconciled and corrected as needed monthly with the Contractor. CoverRx- There has been no need for a CoverRx lock box. The current Contractor collects the rebate payments from certain manufacturers and then pays CoverRx. In addition, one manufacturer submits quarterly rebate checks directly to CoverRx. All CoverRx rebate checks are mailed to the Division of TennCare's fiscal office. CoverKids-Currently CoverKids rebate checks are also mailed directly to Division of TennCare from the rebate vendor which presently is different from both CoverRx and TennCare. We are open to handling CoverKids differently when it is under the Division of TennCare Pharmacy beginning January 1, 2020.
A.43.e	Pg.121	253 Does the current rebate vendor provide TennCare	No. TennCare does not currently use the services of a data aggregator.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		utilization to data aggregators (e.g., Data Niche or Kalderos? If so, is the rebate vendor allowed to charge the data aggregator for the work performed? Language: The Contractor shall provide to the agency or business of the State's choosing, any and all appropriate, accurate, and balanced pharmacy level claims data needed to resolve or avoid any Medicaid or supplemental drug rebate disputes. This pharmacy level claims data shall be provided within fifteen (15) business days of the request by the State.	
A.43.e.1.	Pg.121	254 Are the supplemental rebate contracts currently in place between the State and the manufacturers or between the current vendor and the manufacturers? Language: TennCare Supplemental Rebates	Supplemental rebate contracts will be negotiated by the winning respondent, and will be in place between the State and the manufacturers.
A.43.e.1.	Pg. 121	255 What is (are) the term date(s) for the supplemental rebate contracts currently in place? Language: TennCare Supplemental Rebates	9/30/2019 is the termination date of current supplemental rebate contracts.
A.55.a.1.(e)	Pg.164	256 Is the State currently receiving rebates for CoverRx utilization? If so, are rebate contracts between the State and manufacturers or between	Yes. Contracts are between the manufacturer and the rebate vendor. Currently just Brands but looking to expand.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		the State's current rebate vendor and manufacturers? If the State is currently receiving rebates, are rebates limited to brand products or is the State receiving rebates for generic products? Language: Rebate contracting and administration: . . . The Contractor shall negotiate contracts for CoverRx rebates and submit all manufacturer proposals and contracts to the State for review and approval . . .	
A.55.a.1.(e)	Pg.164	257 Is the State receiving rebates for vaccines? Is the State receiving rebates for products not listed on the CoverRx Covered Drug List? If so, please identify the products. Does the Contractor issue payments to the providers from its own bank account or is there a State funded bank account that is used for such payments?	At this time CoverRx does not receive rebates for vaccines. Rebates are only for products on the Covered Drug List. Yes, Contractor issues payments to providers from its own bank account.
A.56.b.2(c)	Pg.172	258 Does the Contractor issue payments to the providers from its own bank account or is there a State funded bank account that is used for such payments? Language: The Contractor shall mail checks and RAs to pharmacy providers weekly on Fridays for all claims submitted through the POS online pharmacy claims processing system……	Contractor will be required to issue payments to providers from its own bank account.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
A.57.h.1.	Pg.181	259 Are the actual results from the pharmacoeconomic modeling presented to the CoverRx Clinical Advisory Committee or just the pharmacoeconomic review criteria? If the actuals results are presented, is information regarding rebates withheld or presented?	Pharmacoeconomic data is not used during presentations to the CoverRx Clinical Advisory Committee.
A.57.j.1.	Pg.182	260 For the CoverRx Program, please identify the current total amount of uncollected receivables by rebate quarter. In regard to uncollected rebate receivables, please confirm that the Contractor will only assume responsibility for the collection thereof and will not assume responsibility for paying the actual debt. Language: The Contractor shall process, invoice, and collect rebates through the Contractor's rebate administration systems, and shall assume all responsibility for uncollected receivables at the time of the contract date.	None.
A.57.j.1.	Pg.182	261 Please identify CoverRx's current rebate vendor. Language: The Contractor shall import historical quarterly rebate data into their rebate management system, provided by CoverRx's	Magellan Rx Management-Commercial Rebates

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		current rebate vendor.	
A.57.j.1.	Pg.182	262 Is all the historical data that the Contractor will receive in an electronic format? If not, please identify by rebate quarter and data type (e.g., claims, invoices, payments, disputes) the historical data that will be provided in an electronic format and the historical data that will not be provided in an electronic format. Language: The Contractor shall import historical quarterly rebate data . . .	Yes.
A.57.j.1.	Pg. 182	263 For historical data, will invoice data be provided by rebate quarter / NDC and include original invoice records and prior quarter adjustments? If not, please explain or provide the layout of the invoice data that the Contractor will receive. Language: The Contractor shall import historical quarterly rebate data . . .	Yes.
A.57.j.1.	Pg.182	264 For historical data, will payment data include check number, payment postmark date, rebate quarter / NDC? If not, please explain or provide the layout of the payment data that the Contractor will receive. Language: The Contractor shall import	Yes.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		historical quarterly rebate data . . .	
A.57.j.1.	Pg.182	265 For historical data, will dispute status information (e.g., resolved, unresolved) be provided? If not, please explain how the status of a dispute will be conveyed to the Contractor. If so, will dispute status information be provided by rebate quarter / NDC? If not, please explain or provide the layout of the disputes status information that the Contractor will receive. Language: The Contractor shall import historical quarterly rebate data . . .	There are no unresolved disputes. Also, no history of disputes with CoverRx rebates.
A.57.j.1.	Pg.182	266 Will the Contractor be required to take ownership of any paper rebate documentation from the current rebate vendor? If so, approximately how many boxes of rebate documentation will the Contractor be required to take and where (city and state) is it currently located? Will the Contractor be required to assume any costs of transferring paper documents from the current rebate vendor or will the current rebate vendor be responsible for any costs? Language: The Contractor shall import historical quarterly rebate data . . .	No.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
A.57.j.r	Pg.183	267 Is it expected that the Contractor will establish and maintain a bank account on behalf of the State that will be solely designated for the collection of CoverRx rebates for the State? If so, what is the schedule and preferred method for Contractor's submission of rebates to the State? Language: One hundred percent (100%) of all monies collected on behalf of the State shall be remitted to the State. The Contractor agrees that all rebates collected on behalf of the State shall be collected for the sole benefit of the State's share of costs, and that no other monies other than rebates shall be collected base on the State's program.	All funds for TennCare Medicaid drug rebates shall be deposited into a state owned bank account via lock box. Rebate checks for CoverKids and Cover Rx are remitted directly to the State due to the low volume.
A.61.a.5. &7.	Pg.190	268 Please provide examples of the Quarterly Net Cost trend and Rebate reports. Language: CoverRx Management Reports	Net cost trend and rebate reports contain proprietary rebate information protected under both Federal and State statutes. The SRA approved by CMS, citing federal law, 42 USC 1396r-8(b)(3)(D), requires the parties to maintain confidentiality and **not** disclose terms, conditions or pricing information to third parties. Currently TCA 71-5-197 (d) and (e) track the federal requirements. Any amendment to these sections allowing public disclosure would violate federal statute, CMS approval, and the SRA currently in effect with manufacturers. Report parameters will be provided to the wining respondent. However, TennCare would be seeking to confirm quarterly trend based on YoY analysis and change in delta. Contractor

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
			should include top drivers of pharmacy reimbursement and net spend per claim andclaims volume, in both traditional outpatient and outpatient specialty drug categories. Contractor will be asked toanalyze how TennCare trend compares with other Medicaid states of similar size and volume of claims. In addition, the average pharmacy utilizer per month and cost per claim for both special and generalized outpatient drug categories in caparison to YoY trend. Other areas of interest to TennCare include PDL compliance, opportunities for PDL generated savings strategies, drugs driving rebate collections or Brand over Generic initiatives, new drugs in the pipeline, treatment niche and projected cost/impact.
A.72.b.4(b)	Pg.197	269 Does the Contractor issue payments to the providers from its own bank account or is there a State funded bank account that is used for such payments? Language: The Contractor shall mail checks and remittance advices for claims that were submitted through its CoverKids POS system for that work week on Friday....	The Contractor will issue payments to Providers from a Contractor owned bank account.
A.72.a	Pg.198	270 Please provide the CoverKids help desk/call center volumes, including number of calls and call handle times. Language: CoverKids POS System Overview	See the answer to Question #69.
A.73.k.1.	Pg.214	271 Please identify CoverKids' current rebate vendor. Language:	BCBS of Tennessee.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		The Contractor shall import historical quarterly rebate data into their rebate management system, provided by CoverKids' current rebate vendor.	
	Pg.214	272 Is all the historical data that the Contractor will receive in an electronic format? If not, please identify by rebate quarter and data type (e.g., claims, invoices, payments, disputes) the historical data that will be provided in an electronic format and the historical data that will not be provided in an electronic format. Language: The Contractor shall import historical quarterly rebate data into their rebate management system, provided by CoverKids' current rebate vendor.	Yes.
A.73.k.1.	Pg.214	273 For historical data, will invoice data be provided by rebate quarter / NDC and include original invoice records and prior quarter adjustments? If not, please explain or provide the layout of the invoice data that the Contractor will receive. Language: The Contractor shall import historical quarterly rebate data into their rebate management system, provided by CoverKids' current rebate vendor.	Yes.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
A.73.k.1.	Pg.214	274 For historical data, will payment data include check number, payment postmark date, rebate quarter / NDC? If not, please explain or provide the layout of the payment data that the Contractor will receive. Language: The Contractor shall import historical quarterly rebate data into their rebate management system, provided by CoverKids' current rebate vendor.	Payment data will include payment post mark, rebate quarter/NDC and invoice number instead of check number.
A.73.k.1.	Pg.214	275 For historical data, will dispute status information (e.g., resolved, unresolved) be provided? If not, please explain how the status of a dispute will be conveyed to the Contractor. If so, will dispute status information be provided by rebate quarter / NDC? If not, please explain or provide the layout of the disputes status information that the Contractor will receive. Language: The Contractor shall import historical quarterly rebate data into their rebate management system, provided by CoverKids' current rebate vendor.	Dispute status information will not be provided. Historical disputes will need to be resolved by the rebate vendor that was responsible for the rebate payment, as the payment is based on their contractual relationship with the manufacturers.
A.73.k.1.	Pg.214	276 Will the Contractor be required to take ownership of any paper rebate documentation from the current rebate vendor? If so, approximately how	No.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		many boxes of rebate documentation will the Contractor be required to take and where (city and state) is it currently located? Will the Contractor be required to assume any costs of transferring paper documents from the current rebate vendor or will the current rebate vendor be responsible for any costs? Language: The Contractor shall import historical quarterly rebate data into their rebate management system, provided by CoverKids' current rebate vendor.	
A.73.k.	Pg.213	277 Is the State currently receiving rebates for CoverKids utilization? If so, are rebate contracts between the State and manufacturers or between the State's current rebate vendor and manufacturers? Language: CoverKids Rebate Administration	Yes, the State is currently receiving rebates for CoverKids utilization. The rebate contracts are between the State's current rebate vendor and Manufacturers.
A.73.k.1.	Pg.213	278 For the CoverKids Program, please identify the current total amount of uncollected receivables by rebate quarter. In regard to uncollected rebate receivables, please confirm that the Contractor will only assume responsibility for the collection thereof and will not assume responsibility for paying the actual debt. Language:	PBM Rebate Quarter PBM Billed Rebate Dollars* 1Q2018 $1,278,279.18 2Q2018 $1,133,259.81 Medical Rebate Quarter Medical Billed Rebate Dollars* 2Q2018 $16,606.17 *Billed rebate dollars may not be paid at 100% due to claims denied by manufacturer.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		The Contractor shall process, invoice, and collect rebates through the Contractor's rebate administration systems, and shall assume all responsibility for uncollected receivables at the time of the contract date.	
A.73.k.4	Pg.214	279 Is it expected that the Contractor will establish and maintain a bank account on behalf of the State that will be solely designated for the collection of CoverRx rebates for the State? If so, what is the schedule and preferred method for Contractor's submission of rebates to the State? Language: One hundred percent (100%) of all monies collected on behalf of the State shall be remitted to the State. The Contractor agrees that all rebates collected on behalf of the State shall be collected for the sole benefit of the State's share of costs, and that no other monies other than rebates shall be collected base on the State's program.	All funds for TennCare Medicaid drug rebates shall be deposited into a state owned bank account via lock box. Rebate checks for CoverKids and Cover Rx are remitted directly to the State on a quarterly basis. Contractor is not expected to establish a bank account solely for the collection of CoverRx or CoverKids rebates.
Attachment D	Pg.280	280 Please provide an example of the Monthly Rebate Negotiations Status Report. Please provide examples of the following reports: 5) Federal Rebate And Supplemental Rebate data,	Reports will be shared with the winning respondent during Implementation meetings. Net cost trend and rebate reports contain proprietary rebate information protected under both Federal and State statutes. The SRA approved by CMS, citing federal law, 42 USC 1396r-8(b)(3)(D), requires the parties

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		6) Pre-Invoice Summary, 7) Rebate Invoicing, 8) Delinquent Rebate Payment Notices, 10) Rebate Postmark Date, 11) Fire-Account Receivable, 12) Drug Rebate Dispute Data / Rebate Dispute Resolution, 13) Delinquent Rebate Payment Interest Accrual, 14) claim Processing Exclusion, 15) 340B Exclusion; 16) Labeler Account Balance: 34) Supplemental Rebate Negotiations Status Language: TennCare Management Reporting Requirements	to maintain confidentiality and **not** disclose terms, conditions or pricing information to third parties without written consent of the other party. Currently TCA 71-5-197 (d) and (e) track the federal requirements. Any amendment to these sections allowing public disclosure would violate federal statute, CMS approval, and the SRA currently in effect with manufacturers.
A.79.e.3.	Pg.226	281 Please provide an example of the Monthly Rebate Negotiations Status Report. Language: CoverKids Formulary Compliance Reports	Not available.
Attachment G – TennCare PBM Program Performance Metrics, Table 2 (CoverRx Program), item 5.	Pg.292	282 Please clarify if the appropriate document to reference is Attachment E which pertains to the CoverRx Program. Language: Reporting: Required Reports No more than two (2) of the required reports referenced in Attachment D are	Yes. Confirmed correct reference is Attachment E for the CoverRx Program. See revised Attachment G.

RFP SECTION	PAGE #	QUESTION / COMMENT	STATE RESPONSE
		incomplete and/or untimely in a single month	
Attachment G – TennCare PBM Program Performance Metrics, Table 3 (CoverKids Program), item 5.	Pg.293	283 Please clarify if the appropriate document to reference is Attachment F which pertains to the CoverKids Program. Language: Reporting: Required Reports No more than two (2) of the required reports referenced in Attachment D are incomplete and/or untimely in a single month	Yes. Confirmed correct reference is Attachment F for the CoverKids program. See revised Attachment G.

3. **Delete RFP section A.54. in its entirety and replaced with the following** (any sentence or paragraph containing revised or new text is highlighted):

A.54. TennCare Program Performance Improvement Projects (PIPs)

A.54. The Contractor shall conduct performance improvement projects (PIPs) in accordance with federal law and CMS protocols, including but not limited to 42 C.F.R. § 438.330. All PIPs must be approved by TennCare prior to implementation. TennCare reserves the right to provide further direction and guidance on PIPs via the Control Memorandum Process outlined in Contract Section A.5.~~perform at least one (1) clinical and one (1) non-clinical PIP. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care; nonclinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and other complaints.~~

~~A.54.b. The Contractor shall follow CMS protocols for PIPs and document all steps outlined in the CMS protocols for performance improvement projects.~~

~~A.54.c. The Contractor shall identify benchmarks and set achievable performance goals for each of its PIPs. The Contractor shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.~~

~~A.54.d. Following a three (3) year measurement period, PIPs must be evaluated using criteria established by TennCare to determine whether the PIPs should be continued. As applicable, the Contractor shall accept all PIP information and data collected from the former Contractor so that all CMS protocols for PIPs are followed for the remainder of the three (3) year period.~~

~~A.54.e. The Contractor shall submit an annual Report on Performance Improvement Projects that includes the information specified in this Section. For Performance Improvement Project topics that are conducted in more than one region of the State, the Contractor shall submit one Performance Improvement Projects Summary Report that includes region-specific data and information, including improvement strategies. The report shall be submitted annually on July 30.~~

4. **Delete RFP section A.80.a.7. in its entirety due to duplication.** (any sentence or paragraph containing revised or new text is highlighted)

~~A.80.a.7. Response to prescriber on outcome of prior authorization request. This may be completed by utilizing facsimile technology.~~

5. **RFP Attachment A, Definition number 46, is deleted in its entirety and re-numbered (See Updated Attachment A Below):** (any sentence or paragraph containing revised or new text is highlighted)**:**

6. **RFP Attachment G, Table 1 TennCare Program # 3, Table 2 CoverRx Program # 5, and Table 3 CoverKids Program # 5 are deleted in its entirety and replaced with the following (See Updated Attachment G Below):):** (any sentence or paragraph containing revised or new text is highlighted)

7. **RFP Attachment 6.7, Bidder's Library, is deleted in its entirety and replaced with the following (See Updated Attachment 6.7 Below):):** (any sentence or paragraph containing revised or new text is highlighted)

8. **RFP Amendment Effective Date.** The revisions set forth herein shall be effective upon release. All other terms and conditions of this RFP not expressly amended herein shall remain in full force and effect.

RFP Amendment 7 Attachment 1

Top 10 retail pharmacies (by claim volume) for SFY 18

Pharmacy Name		City	State	% Claim Count
WALGREENS #3176		MEMPHIS	TN	0.59
WALGREENS #3798		KNOXVILLE	TN	0.52

WALGREENS #13659		**JACKSON**	**TN**	**0.48**
WALGREENS #10688		**NEWPORT**	**TN**	**0.46**
WALGREENS #10103		**MEMPHIS**	**TN**	**0.4**
WALGREENS #3221		**MADISON**	**TN**	**0.4**
WALGREENS #6223		**CROSSVILLE**	**TN**	**0.39**
WALGREENS #7659		**COLUMBIA**	**TN**	**0.39**
WALGREENS #5869		**NASHVILLE**	**TN**	**0.38**
WALGREENS #6882		**MEMPHIS**	**TN**	**0.38**

ATTACHMENT A

DEFINITIONS AND ACRONYMS

Any terms and acronyms used in this Contract that are not defined herein shall have the meaning set forth in the TennCare Rules, the CoverRx statutory authority (T.C.A. § 56-57-101 et seq.) or the CoverKids statutory authority (T.C.A. § 71-3-1101 et seq., the State Child Health Plan under Title XXI of the Social Security Act State Children's Health Insurance Program, and the State Rules are 0620-05-01 et seq), respectively, as applicable based on the PBM Program being referred to. The following terms and acronyms used in this Contract shall have the meanings set forth below. In the event of a conflict between the definitions set forth herein and those contained in the TennCare Rules, the CoverRx statutory authority (T.C.A. § 56-57-101 et seq.), or the CoverKids statutory authority (T.C.A. § 71-3-1101 et seq., the State Child Health Plan under Title XXI of the Social Security Act State Children's Health

Insurance Program, and the State Rules are 0620-05-01 et seq), respectively, the definitions set forth in this Contract shall govern.

1. **340B Pharmacy -** A pharmacy participating in a special drug discount program authorized by Section 340B of the Public Health Service Act. Participation is limited to the following types on providers: Consolidated Health Centers, AIDS clinics and drug programs, Black Lung Clinics, Federally Qualified Health Center Look-a-likes, Disproportionate Share Hospitals, Hemophilia treatment centers, Native Hawaiian health centers, Urban Indian clinics/638 tribal centers, Title X family planning clinics, STD clinics, TB clinics.

2. **834 File –** An ASC X12N file that contains 834 transactions. TennCare creates 834 files as part of the nightly enrollment cycle. Files are normally delivered to the receiving trading partner mid-morning each business day.

3. **834 Enrollee Transaction (834 Transaction) –** A series of 834 loop records that contain the enrollment information for a given TennCare member. The 834 Transaction may indicate current active enrollment or terminated enrollment.

4. **ACD -** Automatic Call Distributor (ACD) is a system or devise that distributes incoming calls to a specific group of representatives and designated terminals.

5. **Actual Cost Avoidance -** The actual cost that TennCare would have paid for a TennCare claim had the claim not been eligible for reimbursement by TPL.

6. **Adverse Benefit Determination** – As defined in 42 C.F.R. §438.400(b), including but not limited to any of the following actions or proposed actions taken by Contractor:
   (1) The denial or limited authorization of a requested benefit, including determinations based on:
      (a) type or level of benefit,
      (b) requirements for medical necessity,
      (c) appropriateness, setting, or
      (d) effectiveness of a covered benefit.
   (2) The reduction, suspension, or termination of a previously authorized covered benefit.
   (3) The denial, in whole or in part, of payment for a benefit.
   (4) The failure to authorize and arrange provision of a benefit within TennCare agency-prescribed timeframes, and
   (5) For a resident of a rural area with only one Contractor PBM Provider, the denial of an enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network.
   (6) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

7. **Appeal** – Synonymous with an enrollee request for a State fair hearing. CMS has determined that the provisions contained in 42 C.F.R. 438 subpart F, which require PAHPs to maintain an internal appeal system, and which require enrollee to exhaust the PAHP internal appeal process before being permitted to request a State fair hearing, are satisfied by the TennCare agency's requirement that Contractor comply with the "Reconsideration" phase of the TennCare appeal process. In accordance with CMS approval, the Contractor will not have an internal appeal process that enrollees are required to exhaust before they may request a TennCare appeal and attendant State fair hearing. The Contractor's "Reconsideration" (during the TennCare appeal process) of its adverse benefit determination is deemed by CMS to satisfy the requirement for a PAHP-level appeal.

8. **Appeal System** – Synonymous with TennCare appeal process, with state fair hearing system, and state fair hearing process. References to Contractor Appeal System or Contractor Appeal

Process refers to both (1) the processes the Contractor implements to comply with its state fair hearing process-related obligations such as timely issuance of a compliant NABD, timely compliance with the Reconsideration phase, timely compliance with TennCare-issued directives, etc., and (2) the processes the Contractor implements to collect, track and maintain the information gathered in accordance with the state fair hearing process.

9. **Ambulatory Pharmacy -** For TennCare Program purposes, and exclusive of TennCare Specialty Pharmacy services, this type of pharmacy is a chain drug store or independent pharmacy or any other entity licensed by the Tennessee Board of Pharmacy, or an entity duly licensed by any State Pharmacy Board, to dispense prescriptions directly to outpatient TennCare enrollees (other than by mail order) in any ambulatory setting. In order to be considered an ambulatory pharmacy, at least 75% of the pharmacy's prescription volume must consist of face to face interactions with customers. NCPDP Dispenser Class and Type "7" (Dispensing Physicians) are not eligible for enrollment as an Ambulatory Pharmacy.

10. **AMP -** Average Manufacturer Price is a reference drug price calculated by CMS. It is based on data provided by pharmaceutical manufacturers. This value is used to calculate Medicaid Drug Rebates for state Medicaid programs.

11. **AWP -** Average Wholesale Price is a reference price for prescription drug products. Pharmacy reimbursement can be calculated based on AWP minus a percentage. The AWP amount is provided by commercial publishers of drug pricing data such as First Data Bank or Thomson Medical Economics.

12. **Business Interruption -** Any disruption in operations that is equal to or longer than ten (10) minutes in duration**.**

13. **Clean Claim -** A claim received by the PBM for adjudication, and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the PBM.

14. **CHF -** Congestive Heart Failure is a condition in which the heart's function as a pump to deliver oxygen rich blood to the body is inadequate to meet the body's needs.

15. **CHIPRA** - Children's Health Insurance Program Reauthorization Act, a federal law.

16. **CMS -** The federal Centers for Medicare and Medicaid Services.

17. **Copay –** The amount certain TennCare, CoverRx and CoverKids should pay for certain Pharmaceutical Services in accordance with the TennCare waiver, CoverRx statutory authority (T.C.A. § 56-57-101 et seq.), and the CoverKids statutory authority (T.C.A. § 71-3-1101 et seq., the State Child Health Plan under Title XXI of the Social Security Act State Children's Health Insurance Program, and the State Rules are 0620-05-01 et seq.), respectively.

18. **Covered Services** – Covered Services differ by PBM Program as follows:
(a) For TennCare enrollees, this is a medication or service authorized under TennCare Rules 1200-13-13-04 and/or 1200-13-14.04 that has been prescribed for an eligible TennCare enrollee by an authorized prescriber, with reimbursement for covered medications by the TennCare Program contingent upon a prescription issued by a licensed provider. A link to the TennCare PDL and TennCare Pharmacy Manual can be found on the TennCare website;
(b) For CoverRx members, this is a medication or service authorized under T.C.A. § 56-57-101 et seq. that has been prescribed for an eligible CoverRx member by an authorized prescriber, with reimbursement for covered medications by the CoverRx Program contingent upon a prescription issued by a licensed provider. A link to the CoverRx CDL and CoverRx Pharmacy Manual can be found on the CoverRx website; and

(c) For CoverKids members, this is a medication or service authorized under T.C.A. § 71-3-1101 et seq., the State Child Health Plan Under Title XXI of the Social Security Act State Children's Health Insurance Program and State Rules 0620-05-01 et seq. that has been prescribed for an eligible CoverKids member by an authorized prescriber, with reimbursement for covered medications by the CoverKids Program contingent upon a prescription issued by a licensed provider. A link to the CoverKids PDL and CoverKids Pharmacy Manual will be provided on the CoverKids website prior to CoverKids Go Live.

19. **CoverKids Group One Children** - Enrollees who are members of families with incomes between two hundred and five percent (205%) and two hundred fifty five percent (255%) of the federal poverty level (FPL) as reported by the State to the Contractor for the coverage period.

20. **CoverKids Group Two Children** - Enrollees who are members of families below two hundred and four percent (204%) of FPL as reported by the State to the Contractor for the coverage period.

21. **CoverKids Member Handbook** - The Member Handbook that is approved by the State for Members of the CoverKids program.

22. **CoverKids Provider -** An institution, facility, agency, person, corporation, partnership, or association approved by the State which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with the Contractor.

23. **CoverRx Provider -** An institution, facility, agency, person, corporation, partnership, or association approved by the State which accepts as payment in full for providing benefits the amounts paid pursuant to a pharmacy provider agreement with the Contractor.

24. **CSR -** Customer Service Representative is a person working in a Contractor's help desk/call center operation.

25. **Complete Claim –** Any claim received by the PBM for adjudication where sufficient information has been provided to permit the claim to have been either denied or allowed

26. **Data Dictionary -** A set of information describing the contents, format, and structure of a database and the relationship between its elements, used to control access to and manipulation of the database.

27. **Data Mapping** – In simple terms, means to map source data fields to their related target data fields

28. **DAW (Dispense as Written)** - A prescription that cannot be filled with a generic because the prescriber has indicated Dispense as Written on the prescription.

29. **Disaster -** A negative event that significantly disrupts business operations for more than one (1) hour.

30. **Disenrollment -** The discontinuance of a TennCare, CoverRx or CoverKids member's entitlement to receive Covered Services under the terms of this Contract, and deletion from the approved list of enrollees furnished by the State to the Contractor.

31. **Dispensary** – A dispensing physician who dispenses medication to enrollees in his/her office.

32. **DDI Phase –** Design, development and implementation phase of the process of creating Contractor's PBM systems to be used to provide services to the TennCare PBM Programs.

33. **DEA Number -** A Drug Enforcement Agency (DEA) Number is a series of numbers assigned to a health care provider allowing them to write prescriptions for controlled substances. The DEA number is often used as a prescriber identifier.

34. **Drug Efficacy Study Implementation (DESI) Drug -** A drug that has been designated as experimental or ineffective by the Food and Drug Administration (FDA).

35. **DSS -** A decision support system is a database and query tool.

36. **DUR -** Drug Utilization Review is program is to improve patient safety and care and to reduce overall drug costs. Medicaid DUR programs are required by the federal Omnibus Budget Reconciliation Act of 1990 to provide prospective claim edits retrospective analysis and educational programs.

37. **Eligible Individuals** - Persons who meet criteria for TennCare, CoverRx or CoverKids eligibility established by the State within its statutory authority as of the effective date of this Contract.

38. **Enrollment** - The date the Contractor enters the TennCare, CoverRx or CoverKids applicant's data into Contractor's core processing system.

39. **EMC -** Electronic Media Claims.

40. **Enrollee -** Any eligible individual who has enrolled in the TennCare Program, CoverRx Program, or the CoverKids Program in accordance with the rules and regulations of the applicable program. For purposes of the appeals system-related provisions herein, "Enrollee" means enrollee, enrollee-authorized representative, or someone with written consent to act on enrollee's behalf. (Enrollee is synonymous with Member, Participant or Recipient).

41. **Ethical and Religious Directives (often called the ERDs)** - means a document that offers moral guidance on various aspects of health care delivery and is based on a religious organization's theological and moral teachings.

42. **FAR -** Federal Acquisition Regulation

43. **FAQs -** Frequently Asked Questions.

44. **FDA -** Federal Drug Administration

45. **FIR -** Functional and Informational Requirements.

~~46. **First Fill Date –** For purposes of determining when the Contractor is entitled to receive a TPL Fee for POS Actual Cost Avoidance savings, the term "first fill date" shall mean the day on which the new TPL information provided by the Contractor's POS system to the pharmacy attempting to fill an enrollee prescription results in a NCPDP Code 41.~~

46. **FTE -** Full time equivalent position.

47. **FUL -** Current Federal Upper Limit price as listed by CMS.

48. **GCN -** Generic Code Number.

49. **Go Live –** The date and time upon which the Contractor assumes all PBM responsibility and functions for each of the TennCare PBM Programs from the previous TennCare PBM contractors.

50. **Grievance** – A complaint or an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision. See 42 C.F.R. §438.400(b).

51. **Grievance System** – The processes the Contractor implements to handle grievances, as well as the processes to collect and track information about them. See 42 C.F.R. §438.400(b).

52. **GSN -** Generic Sequence Number.

53. **Tennessee Medicaid provider number –** A unique identification number assigned by TennCare to a person or entity seeking to provide services for any TennCare program following the person's or entity's successful registration with the State through the TennCare Provider Registration Portal located at [add website link here]. A TennCare ID Number is required to submit a claim for reimbursement to the State for services provided to an enrollee of the TennCare, CoverRx or CoverKids Program.

54. **TennCare Record** - Any record, in whatever form, including but not limited to, medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution involving any TennCare PBM Program or any enrollees of such TennCare PBM Programs.

55. **HIPAA -** Health Insurance Portability and Accountability Act of 1996 which mandates the use of standards for the electronic exchange of health code data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payors (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of individually identifiable health care information.

56. **HITECH –** The Health Information Technology for Economic and Clinical Health Act which was enacted to improve health care quality, safety, and efficiency through the promotion of health information technology (HIT) and the electronic exchange of health information; to adopt an initial set of standards, implementation specifications, and certification criteria to enhance the interoperability, functionality, utility, and security of health information technology; and, to establish the capabilities and related standards that certified electronic health record (EHR) technology (Certified EHR Technology) shall need to include in order to, at a minimum, support the achievement of the proposed meaningful use by eligible professionals and eligible hospitals.

57. **Hot Site -** An alternative facility with the capability to readily assume responsibility for carrying out the activities carried out at the Contractor's main site.

58. **Incomplete Claim** – Any claim received by the PBM for adjudication that cannot either be denied or allowed due to insufficient information and/or documentation that is needed from the provider in order to allow or deny the claim.

59. **IVR or IVRU -** Interactive voice response unit is a telephone technology that allows a computer to detect voice and touch tones using a phone call and provide individualized system generated information for callers.

60. **IRS -** Drugs that are identical, related or similar (IRS) to drugs identified as less than effective (LTE) by the FDA.

61. **Limited English Proficiency (LEP) -** As defined at 42 CFR 438.10(a), means potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

62. **Lock In -** A restrictive logic that limits claims at point of sale to selected prescribers or pharmacies. Members under this restriction are said to be "locked-In".

63. **Lock In Pharmacy -** The Pharmacy that shall be the exclusive provider for certain covered pharmacy services for enrollees chosen and assigned by the State.

64. **Long-Term Care Facility -** An institution which provides one of the following services: a nursing facility (NF); an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or a Home and Community-Based Services (HCBS) waiver program.

65. **Long Term Care Pharmacy Provider –** An entity licensed by the Tennessee Board of Pharmacy or duly licensed by any State Pharmacy board to dispense prescriptions to or for residents of a Long Term Care Facility.

66. **LTE -** Drugs that the FDA considers to be less than effective because there is a lack of substantial evidence of effectiveness for all labeled indications and for which there is no compelling justification for their medical need.

67. **MAC -** Maximum Allowable Cost.

68. **MAC List –** The list of certain prescription drugs and their respective "MAC" prices for which reimbursement shall be made to the Provider. MAC Lists are subject to periodic review by the State and/or the PBM and may be modified from time to time at the State's and/or the PBM's discretion. A link to current MAC rates is included on the TennCare PBM Program website

69. **MCO –** A managed care organization participating in the TennCare program.

70. **MEDD -** Morphine Equivalent Daily Dose

71. **Member -** Any eligible individual who has enrolled in the TennCare, CoverRx, CoverKids, or Optional Program in accordance with the TennCare Rules and Regulations, CoverRx statutory authority (T.C.A. § 56-57-101 et seq.), or the CoverKids statutory authority (T.C.A. § 71-3-1101 et seq.) and State Child Health Plan under Title XXI of the Social Security Act State Children's Health Insurance Program, respectively. (Member is synonymous with Enrollee, Participant or Recipient).

72. **Member Materials –** All materials that will be distributed to enrollees of the TennCare PBM Programs, including, but not limited to, member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, system generated letters and notices, and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.

73. **MMIS –** Medicaid Managed Information System

74. **NCPDP -** National Council of Prescription Drug Programs.

75. **NCPDP Code 41 –** The current National Counsel for Prescription Drug Programs (NCPDP) version Code 41 (meaning "Submit Bill to Other Processor or Primary Payer") which is generated by the Contractor's POS system in response to a query by a pharmacy attempting to fill an enrollee's prescription that indicates the enrollee has other third party insurance (TPL) which causes TennCare to be the secondary, rather than the primary payor for that claim.

76. **NDC -** National Drug Code Number.

78. **NPI -** National Provider Identification Number - A HIPAA Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

78. **NTIS -** National Technical Information Service operated by the US Department of Commerce.

79. **Network –** A group of pharmacy providers contracted by the Contractor to perform specified services for the TennCare, CoverRx, CoverKids or Optional Programs. Some of these programs, such as TennCare and CoverKids, may have more than one (1) provider Network at a time, such as the CoverKids Ambulatory Network, CoverKids Specialty Network, CoverKids MTM Network, the CoverKids Ambulatory Network and the CoverKids Specialty Network.

80. **OBRA -** Omnibus Budget Reconciliation Act

81. **OTC -** Over-the-counter medications.

82. **Other Insurance** – For purposes of TPL, the term "Other Insurance" shall mean any health insurance an enrollee has in addition to the benefits he/she receives under the CoverKids Program.

83. **PA -** Prior Authorization - A program requirement where certain therapies must gain approval before payment can be authorized.

84. **Participant -** Any eligible individual who has enrolled in the TennCare, CoverRx, CoverKids, or Optional Program in accordance with the TennCare Rules and Regulations, CoverRx statutory authority (T.C.A. § 56-57-101 et seq.), or the CoverKids statutory authority (T.C.A. § 71-3-1101 et seq.) and State Child Health Plan under Title XXI of the Social Security Act State Children's Health Insurance Program, respectively. (Participant is synonymous with Member, Recipient or Enrollee).

85. **PDL -** Preferred Drug List.

86. **Peak Times** – For purposes of this Contract, the term "Peak Times" with regard to pharmacy operations shall mean the period of time from 7a.m. CST through 10 p.m. CST, seven (7) days a week.

87. **PHI -** Protected Health Information, as defined in HIPAA (45 C.F.R. §§ 160 and 164).

88. **POS -** Point-of-Sale.

89. **Prescriber –** An individual authorized by law to prescribe drugs for human consumption.

90. **Prescription Drug -** Pharmaceutical drug that legally requires a medical prescription to be dispensed

91. **Prescription Drug Coverage -** Health insurance or plan that helps pay for prescription drugs and medications

92. **Prevalent Language -** As defined at 42 CFR 438.10(a), means a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.

93. **Pro-DUR -** A point of sale claim edit to facilitate drug utilization review objectives.

94. **Quality Management/Quality Improvement (QM/QI) -** The ongoing process of assuring that the delivery of health care is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical knowledge, and the effort to assess and improve the performance of a program or organization. Quality Improvement includes quality assessment and implementation of corrective actions to address any deficiencies identified.

95. **RA -** Remittance Advice.

96. **Readily accessible -** As defined at 42 CFR 438.10(a), means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

97. **Recipient -** Any eligible individual who has enrolled in the TennCare, CoverRx, CoverKids, or Optional Program in accordance with the TennCare Rules and Regulations, CoverRx statutory authority (T.C.A. § 56-57-101 et seq.), or the CoverKids statutory authority (T.C.A. § 71-3-1101 et seq.) and State Child Health Plan under Title XXI of the Social Security Act State Children's Health Insurance Program, respectively. (Recipient is synonymous with Member, Participant or Enrollee).

98. **Reconsideration -** mandatory component of the TennCare appeal process by which an MCC reviews and renders a decision affirming or reversing the adverse benefit determination at issue in the enrollee's request for a TennCare appeal. An MCC satisfies the plan-level requirements of 42 C.F.R. 438 Subpart F when the review includes all available, relevant, clinical documentation (including documentation which may not have been considered in the original review); is performed by a physician other than the original reviewing physician; and produces a timely written finding. See June 5, 2017, CMS letter from Jackie Glaze to Wendy Long, M.D., M.P.H.

99. **RFP -** Request for Proposal.

100. **Retro-DUR -** A post payment claims analysis to facilitate drug utilization review objectives.

101. **Specialty Drug -** Specialty Drug – A drug that is dispensed via the mail or shipping at least 51% of the time (not typically via retail distribution), does not appear on CMS' NADAC List, and meets at least two (2) of the following criteria:

1. Greater than $500 for a 30-day supply;
2. Drug only approved for limited patient populations;
3. Drug typically injected, infused or requires close monitoring by a physician or clinically trained individual; or
4. Drug has limited availability, special dispensing and delivery requirements and/or requires additional patient support.

102. **Specialty Pharmacy -** A pharmacy that dispenses specialty drugs only and is specialty only as its core business. The pharmacy must be a closed door practice, does not offer retail prescription drugs of any type to retail pharmacy customers, and not open to public walk-in prescription traffic.

103. **State -** The State of Tennessee, including, but not limited to, any entity or agency of the state, such as the Department of Finance and Administration (F&A), the Division of TennCare (TennCare), the TennCare Office of Inspector General (TennCare OIG), , the Medicaid Fraud Control Unit (MFCU), the Department of Mental Health (DMH), the Department of Children's Services (DCS), the Department of Health (DOH), the TennCare Oversight Division within the Department of Commerce and Insurance (C&I) and the Office of the Attorney General (AG).

104. **State Fair Hearing** (SFH) – The process set forth in subpart E of part 431 chapter IV, title 42 under which TennCare enrollees have the right to request a TennCare appeal and the attendant State fair hearing to contest Contractor-proposed Adverse Benefit Determinations. CoverKids enrollees do not have the right to a SFH, but may receive a CoverKids "Review". See 42 CFR §438.400(b).

105. **Step Therapy -** A program requirement to begin drug therapy with the most cost-effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary. The objectives are to control costs and minimize risks.

106. **STS -** Tennessee Strategic Technology Solutions

107. **Subcontract -** An agreement that complies with all applicable requirements of this Contract entered into between the Contractor and another organization or person to perform any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract, (e.g., marketing).

108. **Subcontractor -** Any organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Contract.

109. **System Interruption -** Any event that affects more than five percent (5%) of POS transactions and call center operations, or a data integrity issue that compromises the confidentiality of the system of data contained within the system.

110. **TCA -** Tennessee Code Annotated.

111. **TBI/TBI MFCU -** The Tennessee Bureau of Investigation's Medicaid Fraud Control Unit has the authority to investigate and prosecute (or refer for prosecution) violations of all applicable state and federal laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, the activities of providers of medical assistance in the state Medicaid program (TennCare), allegations of abuse or neglect of patients in health care facilities receiving payments under the state Medicaid program, misappropriation of patients' private funds in such facilities, and allegations of fraud and abuse in board and care facilities.

112. **Total Parenteral Nutrition (TPN) -** A compounded nutritional prescription for patients unable to gain nourishment through their gastrointestinal tract.

113. **UOM -** Unit of Measure.

114. **Vital Documents** – Vital Documents may include, but are not limited to, consent and complaint forms, intake and application forms with the potential for important consequences, notices pertaining to the reduction, denial, delay, suspension or termination of services, certain critical outreach documents and any other documents designated by the State. At a minimum, all Vital Documents shall be available in the Spanish language.

115. **Warm Transfer** - A telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue, and remains engaged as necessary to provide assistance.

116. **Wholesale Acquisition Cost (WAC) - T**he manufacturer's published *catalog* or *list* price for a drug product to wholesalers. WAC does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions in price.

117. **Working Hours –** Working Hours are Monday through Friday from 8:00 a.m. to 4:30 p.m. Central Time (CT), except on official State holidays.

TennCare PBM Program Performance Metrics

Table 1. TennCare Program		
	Program Area	Performance Metric
1.	PA Processing: Complete PAs	Ninety-nine point five percent (99.5%) of all complete PA requests received [phone, fax or email] shall be approved or denied with applicable reasons, within twenty four (24) hours of receipt
2.	PA Processing: Pended PAs	Missing information for Pended PAs shall be obtained by the Contractor and ninety-nine point five percent (99.5%) of all Pended PA Requests shall be approved or denied with applicable reasons, within seventy-two (72) hours of the time they were originally pended
3.	PA Processing: PAs Needing Attestation	Contractor shall provide determination of requested attestations one hundred percent (100%) of the time. Ninety-nine point five percent (99.5%) of attestations with complete information shall be approved or denied with applicable reasons, within ninety-six (96) hours of the time at which it was determined an attestation was needed.
4.	Call Center: Call Response Time	Call response time per day shall be less than thirty (<30) seconds on at least twenty-seven (27) days per month
5	Call Center: Dropped Calls	Calls abandoned (dropped calls) after thirty (30) seconds may not exceed two percent (2%) on more than three (3) days per month.
6.	Reporting: Required Reports	No more than two (2) of the required reports referenced in Attachment D are incomplete and/or untimely in a single month
7.	Reporting: Contractor Data Warehouse	Data warehouse information shall be accessible via the reporting tool provided by Contractor and shall contain all of the data elements required in the Scope of Work, without any data output failures, such as but not limited to, inappropriate duplication or unreported index changes to the data warehouse
8.	Reporting: Ad hoc/ORR Reports	Ad hoc and ORR Reports requested by the State, including those requested from the Contractor's data analyst, shall be complete, accurate, and submitted to the State within the time frame set forth in the State's request.
9..	Adjudication System: System Errors	No inaccuracies in claims analysis, including but not limited to those listed below: a. One hundred percent (100%) of all drugs requiring PA to deny without PA on file; b. One hundred percent (100%) of all claims to be paid with NPI's from prescribers with prescriptive authority; c. One hundred percent (100%) of all patients that have been communicated to the Contractor for Lock-In or PA Status to be locked in and require PA for all controlled substances; d. One hundred percent (100%) of all claims with NDCs that have package quantities including decimals, to be paid only in multiples of the decimal; e. No overrides to be given by Contractor over the fill limit; f. One hundred percent (100%) of non-preferred products to deny at the point of service without PA on file; g. One hundred percent (100%) of newly marketed products to pay only with edits established by the State; and

Table 1. TennCare Program		
	Program Area	Performance Metric
		h. One hundred percent (100%) of claims covered by TennCare shall not be denied using NCPDP denial code “70 - NDC Not Covered”.
10.	Adjudication System: Hours of Operation	No scheduled maintenance of the system shall be performed during Peak Times and the system shall be operational ninety-nine point ninety-nine percent (99.99%) of the time each month, except during an emergency. Failure to operate the system during an emergency shall only be excused if Contractor properly notifies TennCare of the emergency as required in the Contract.
11.	Pharmacy Network: Provider Agreements	The Contractor shall be responsible for oversight and enforcement of its Provider Agreements, including instituting corrective measures when compliance issues are found.
12.	Pharmacy Network: Provider Enrollment	All Providers shall obtain a Tennessee Medicaid provider number prior to being enrolled in the Provider Network by the Contractor, and shall continue to meet all TennCare Provider registration requirements during the entire time that they provide services to the TennCare PBM Programs pursuant to this Contract.
13.	Pharmacy Network: Pharmacy Panel Assignment	Providers shall be assigned to their appropriate pharmacy panel (Pharmacy Panel Assignment) based on TennCare-approved requirements and shall not perform services under this Contract and are outside of each Provider’s panel assignment.

Table 2. CoverRx Program		
	Program Area	Performance Metric
1.	Eligibility Determination: New/Renewal Application Processing	Ninety-five percent (95%) of all new and renewal applications must be processed and a determination of eligibility made within (5) working days of receipt of a completed application.
2.	Eligibility Determination: Enrollee Letters and Communication Materials	Member Communication materials, including but not limited to, identification cards; welcoming letters about the program (including mail order contact information), Covered Drug List; and enrollment denial letters (when applicable), shall be distributed to no less than ninety-five percent (95%) of applicants within one (1) week of eligibility determination.
3.	Call Center: Call Response Time	Call response time per day shall be less than thirty (<30) seconds on at least twenty-seven (27) days per month
4.	Call Center: Dropped Calls	Calls abandoned (dropped calls) after thirty (30) seconds may not exceed two percent (2%) on more than three (3) days per month.
5.	Reporting: Required Reports	No more than two (2) of the required reports referenced in Attachment E are incomplete and/or untimely in a single month
6.	Reporting: Contractor Data Warehouse	Data warehouse information shall be accessible via the reporting tool provided by Contractor and shall contain all of the data elements required in the Scope of Work, without any data output failures, such as but not limited to, inappropriate duplication or unreported index changes to the data warehouse
7.	Reporting: Ad hoc/ORR Reports	Ad hoc and ORR Reports requested by the State, including those requested from the Contractor’s data analyst, shall be complete, accurate, and submitted to the State within the time frame set forth in the State’s request.

Table 3. CoverKids Program		
	Program Area	Performance Metric
1.	PA Processing: Complete PAs	Ninety-nine point five percent (99.5%) of all complete PA requests received [phone, fax or email] shall be approved or denied with applicable reasons, within twenty four (24) hours of receipt
2.	PA Processing: Pended PAs	Missing information for Pended PAs shall be obtained by the Contractor and ninety-nine point five percent (99.5%) of all Pended PA Requests shall be approved or denied with applicable reasons, within seventy-two (72) hours of the time they were originally pended
3.	Call Center: Call Response Time	Call response time per day shall be less than thirty (<30) seconds on at least twenty-seven (27) days per month
4.	Call Center: Dropped Calls	Calls abandoned (dropped calls) after thirty (30) seconds may not exceed two percent (2%) on more than three (3) days per month.
5.	Reporting: Required Reports	No more than two (2) of the required reports referenced in Attachment F are incomplete and/or untimely in a single month
6.	Reporting: Contractor Data Warehouse	Data warehouse information shall be accessible via the reporting tool provided by Contractor and shall contain all of the data elements required in the Scope of Work, without any data output failures, such as but not limited to, inappropriate duplication or unreported index changes to the data warehouse
7.	Reporting: Ad hoc/ORR Reports	Ad hoc and ORR Reports requested by the State, including those requested from the Contractor's data analyst, shall be complete, accurate, and submitted to the State within the time frame set forth in the State's request.
8.	Adjudication System: System Errors	No inaccuracies in claims analysis, including but not limited to those listed below: a. One hundred percent (100%) of all drugs requiring PA to deny without PA on file; b. One hundred percent (100%) of all claims to be paid with NPI's from prescribers with prescriptive authority; c. One hundred percent (100%) of all patients that have been communicated to the Contractor for Lock-In or PA Status to be locked in and require PA for all controlled substances; d. One hundred percent (100%) of all claims with NDCs that have package quantities including decimals, to be paid only in multiples of the decimal; e. No overrides to be given by Contractor over the fill limit; f. One hundred percent (100%) of non-preferred products to deny at the point of service without PA on file; g. One hundred percent (100%) of newly marketed products to pay only with edits established by the State; and h. One hundred percent (100%) of claims covered by TennCare shall not be denied using NCPDP denial code "70 - NDC Not Covered".
9.	Adjudication System: Hours of Operation	No scheduled maintenance of the system shall be performed during Peak Times and the system shall be operational ninety-nine point ninety-nine percent (99.99%) of the time each month, except during an emergency. Failure to operate the system during an emergency shall only be excused if Contractor properly notifies TennCare of the emergency as required in Section A.44.
10.	Pharmacy Network:	The Contractor shall be responsible for oversight and enforcement

Table 3. CoverKids Program		
	Program Area	Performance Metric
	Provider Agreements	of its Provider Agreements, including instituting corrective measures when compliance issues are found.
11.	Pharmacy Network: Provider Enrollment	All Providers shall obtain a Tennessee Medicaid provider number prior to being enrolled in the Provider Network by the Contractor, and shall continue to meet all TennCare Provider registration requirements during the entire time that they provide services to the TennCare PBM Programs pursuant to this Contract.
12.	Pharmacy Network: Pharmacy Panel Assignment	Providers shall be assigned to their appropriate pharmacy panel based on TennCare-approved requirements and shall not perform services under this Contract and are outside of each Provider's panel assignment.

BIDDER'S LIBRARY

(1) MEDICAID ENTERPRISE CERTIFICATION TOOLKIT (MECT) 2.2
Modular Required Artifacts List

https://www.tn.gov/content/dam/tn/tenncare/documents2/1MEDICAIDENTERPRISECERTIFICATIONTOOLKIT.pdf

(2) SAMPLE REPORT TEMPLATES

TennCare Reports

https://www.tn.gov/content/dam/tn/tenncare/documents2/2aSAMPLEREPORTTEMPLATESTennCare.zip

CoverRx Reports

https://www.tn.gov/content/dam/tn/tenncare/documents2/2bSAMPLEREPORTTEMPLATESCoverRx.zip

CoverKids Reports

https://www.tn.gov/content/dam/tn/tenncare/documents2/2cSAMPLEREPORTTEMPLATESCoverKids.zip

(3) Claim Extract Layouts

https://www.tn.gov/content/dam/tn/tenncare/documents2/3ClaimExtractLayouts.xls

(4) 834 Supplemental Documents

https://www.tn.gov/content/dam/tn/tenncare/documents2/4834SupplementalDocuments.pdf

(5) TennCare Member Identification Card-General Requirements

https://www.tn.gov/content/dam/tn/tenncare/documents2/5TennCareMemberIdentificationCardGeneralRequirements.docx

(6) Notices

https://www.tn.gov/content/dam/tn/tenncare/documents2/6Notices.zip

(7) Pharmacy Network

https://www.tn.gov/content/dam/tn/tenncare/documents2/7PharmacyNetwork.xlsx

(8) Drug List and Drug Criteria

PDL:

https://www.tn.gov/content/dam/tn/tenncare/documents2/8aPDLTennCarePDL.PDF

https://www.tn.gov/content/dam/tn/tenncare/documents2/8aPDLTennCareFormulary.zip

Prior authorization Criteria & quantity limits:

https://www.tn.gov/content/dam/tn/tenncare/documents2/8bPriorauthorizationCriteriaquantitylimits.pdf

Additional criteria for agents not listed on the PDL that links from the main page:

https://www.tn.gov/content/dam/tn/tenncare/documents2/8cAdditionalcriteriaforagentsnotlistedonthePDLthatlinksfrom.mht

Auto-exempt list & attestation list are:

https://www.tn.gov/content/dam/tn/tenncare/documents2/8dTennCareAutoExemptList1.pdf

https://www.tn.gov/content/dam/tn/tenncare/documents2/8dTennCareAutoExempt_List2.pdf

Morphine daily equivalents calculations: see CMS reference chart here, please note only products in the short-acting narcotic and long-acting narcotic PDL classes will be subject to the edit:

https://www.tn.gov/content/dam/tn/tenncare/documents2/8eMorphinedailyequivalentscalculations.pdf

Overrides, ICD overrides:

https://www.tn.gov/content/dam/tn/tenncare/documents2/8fOverridesICDoverrides.pdf

(9) MECT 2.2 Checklists

https://www.tn.gov/content/dam/tn/tenncare/documents2/9aMECT22Checklists.zip

Access and Delivery Checklist
Information Architecture Checklist
Integration and Utility Checklist
Intermediary and Interface Checklist
Pharmacy Checklist (MMIS) Module
Standards and Conditions Checklist

(10) TennCare AE – SSP Template, MARS – E 2.0

https://www.tn.gov/content/dam/tn/tenncare/documents2/10TennCareAESSPTemplateMARSE2.pdf

(11) Magellan Health Services TennCare Portal Files

https://www.tn.gov/content/dam/tn/tenncare/documents2/MagellanHealthServicesTennCarePortalfiles.zip